

Annual report 2023-24



June 2024

West Suffolk NHS Foundation Trust

Annual Report and Accounts 2023-24

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

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

1. Performance report

1.1 Overview

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

1.1.1 A message from the chair and chief executive

We are now two years into the delivery of the West Suffolk NHS Foundation Trust strategy, 'First for our patients, staff and the future', which set the direction of the organisation from 2022 to 2027. To help us take action that will allow us to deliver the aims of our strategy, the Trust Board identified these strategic priorities for 2023-24:

- deliver transformative service pathway changes
- give a strong priority to equality, diversity and inclusion (EDI)
- focus on line management development
- step change in delivery on prevention and proactive care
- development of transformation capacity and capability.

One of the Trust's strengths lies in the breadth and scale of services it provides as an integrated organisation, across acute and community services in the county. That integration is progressing all the time, allowing provision of care that meets people's individual needs and takes all their circumstances and lived experience into account.

WSFT is committed to strengthening the collaborative relationships that have been developed across the system, which bring mutual aid provided through alliance working. This goes beyond the excellent work that has been done in recent years to overcome obstacles and bring professionals from partner organisations together in multidisciplinary teams. For example, the clinical education team's partnership with the West Suffolk College is helping to develop the future NHS workforce as well as allowing existing WSFT staff to achieve their full potential. Working with Abbeycroft Leisure, pathways have been developed to help patients regain independence, and support people to make better choices, preventing future ill-health.

Teams across the Trust are achieving great things every day, striving to improve quality, safety and productivity, and participating in both Getting it Right First Time and the Patient Safety Incident Response Framework initiatives. It has been rewarding to see national recognition for the outstanding results achieved by the stroke service and orthopaedic team; and the pulmonary rehabilitation team receiving national accreditation. The services these teams provide exemplify the Trust's priority to support patients to achieve greater independence and the best quality of life possible.

All this work goes on despite the enormous challenges facing this Trust and the whole NHS, and all our services facing ever-increasing demands. The emergency department (ED) faces continuing and often extreme pressures, but there has been a huge amount of work around achieving the nationally mandated target of seeing 76% of patients in our ED within four hours by 31 March 2024. We have seen month-on-month improvements since December 2023 and in March 2024 we achieved 74% patients seen within the timeframe.

It has been heartening to see the enormous amount of work that has been done and the efforts under way to reduce the time people are having to wait for care or treatment. With repeated episodes of industrial action in 2023, and more than 10 days of action having taken place since the start of 2024, there has been an impact on our elective recovery, which made it more difficult for us to meet the Trust's 2023-24 elective recovery objectives. We know how frustrating and debilitating it can be for people to wait for the care they need, and we would like to apologise to all those who are waiting longer than we would like them to.

At the end of March 2024, there were 407 patients waiting over 65 weeks. It is worth noting that in April 2023 there were 15,878 patients to treat in the 65-week wait cohort, so this reduction in the number of patients waiting is a huge achievement. As of the end of March 2024, the number of our longest waiting patients stands at 47 waiting more than 78 weeks. That number includes capacity breaches, choice, complexity and unfit patients.

There has been continued improvement for patients waiting more than 62 days on the cancer pathway, which has reduced from 189 in September 2023 to 68 at the end of March 2024. The work has included a focus on skin cancers, weekend theatre lists; and the introduction of a “straight to treatment” pathway to reduce face to face appointments and waiting times.

Achievement of the 28-day faster cancer diagnosis standard has increased from 54% in September 2023 to 77% in February 2024, which is the latest data available. While there is still a great deal of work to do, these improved results are testament to the commitment of our teams.

Another key strategic priority is ensuring our staff feel valued in their working lives, so that they can provide services that achieve the standard of quality and safety our patients rightly expect. As part of the sustained and genuine effort to look after staff, we have introduced an expanded organisational development and learning team, which is already delivering on support for managers; improving the culture of the organisation, and driving change informed by listening to staff.

There is a new Freedom to Speak Up (FTSU) Guardian, more FTSU and wellbeing champions have been trained; and a programme of Schwartz Rounds launched, all aimed at improving the culture of the organisation. Four staff networks have also been launched and developed, a vital part of the Trust’s commitment to being an inclusive place to work. Efforts are under way to improve the size of our substantive workforce, building and developing on what has been learned from colleagues. When issues are raised or incidents occur, it is a priority to share the learning that arises, helping the Trust and its services to improve.

National awards have been won by the team who support, develop and care for the hundreds of our staff who have come to our Trust from overseas, and who make up one in five of our workforce. The Trust-wide focus on equality, diversity and inclusion is a commitment to listen, learn and take action to show everyone who works at WSFT that they are valued and have the right to feel safe and supported.

This year the problems caused by reinforced autoclaved aerated concrete (RAAC) came to a head in the media, in relation to schools built with this form of concrete, as much of the West Suffolk Hospital was 50 years ago. Thanks to the sustained and expert work of the estates team, the Trust we continue to inspect the building structure and implement required mitigating action.

Fantastic teamwork has also been evident in the response across the Trust to tackling our financial challenges. A huge amount of hard work meant we delivered significant progress against our cost improvement programme over the last financial year. However, our financial position remains incredibly challenging, and as we begin this financial year, we have significant efficiencies to deliver. Getting us back to solid financial footing over the coming years is a key focus and as an organisation we are channelling a huge amount of effort to do this.

The Trust’s strategic priorities are being developed with a focus on transformation: improving clinical pathways, productivity and sustainability; and looking at encouraging better life choices that can prevent future ill-health. Providing personalised care closer to home is supported by increased digital capability, which is enabling the development of community care through the expansion of the virtual ward. Later in 2024, patients will be able to have a variety of diagnostic tests carried out at a community diagnostic centre at Newmarket Community Hospital, where building is under way.

The Future System team continues its work to prepare for the building of a new healthcare facility and meeting future healthcare needs throughout our locality. There is a sense of enormous progress through the year and the pace that has been brought to the work. The Trust is now at the head of the queue for West Suffolk Hospital to be rebuilt and it's a question of when, not if, West Suffolk will have its new hospital. There is an enormous amount of work still to do, the next stages include developing a business case that will achieve regional and national approval.

This is the local hospital and provider of services in the community for our 5,500 staff plus all their friends and family, which underlines the importance of this Trust to the people of Suffolk and neighbouring counties.

The efforts of volunteers and supporters in our community are evident in the work of both the My WiSH Charity and The Friends of the West Suffolk Hospital. My WiSH continues its excellent work to enhance the care of patients and the working lives of staff, and we are so grateful for the fundraising efforts of the many businesses and individuals who support its work. The Friends charity this year donated nearly £90,000 to fund items requested by staff to improve patient care, raised through donations, legacies and the much-loved WSH Friends shop.

Recently the Foundation Trust has elected new members to the Council of Governors for the next three years, working with executive and non-executive directors of the Board to make sure services are meeting the needs of the community. The 14 public governors sit alongside five staff governors and seven governors nominated to represent partner organisations, and we look forward to working with them.



Jude Chin
Chair
25 June 2024



Dr Ewen Cameron
Chief executive
25 June 2024

1.1.2 About our Trust – a summary

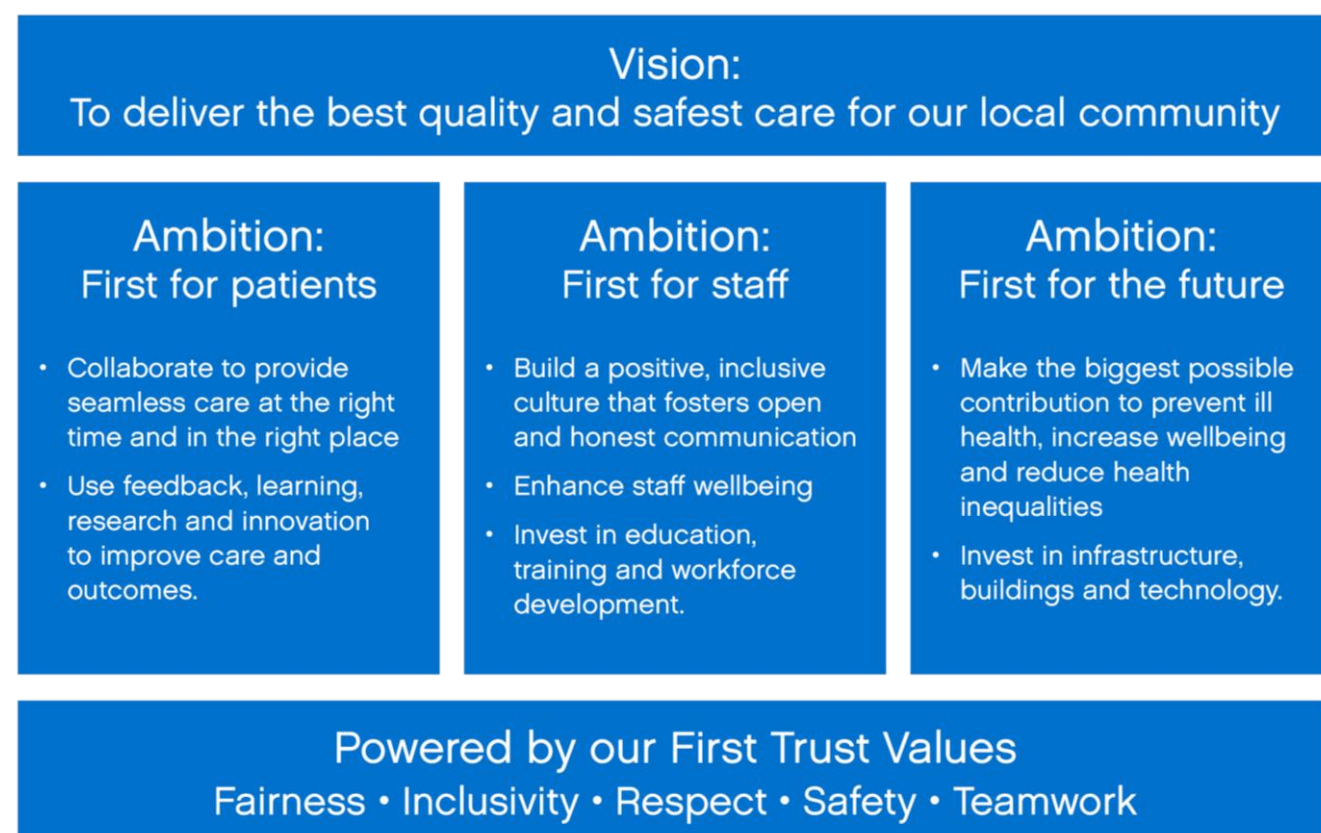
The WSFT provides hospital and community healthcare services to people mainly in the west of Suffolk, and is an associate teaching hospital of the University of Cambridge.

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

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

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

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



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

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

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

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

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

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

Our sites and services

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

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

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

We provide a number of outreach services to our population across various sites in Newmarket, Botesdale, Thetford, Stowmarket, Haverhill, Sudbury, Needham Market and Watton. This includes outpatient clinics and some diagnostic imaging – Newmarket Community Hospital (X-ray), Sudbury Community Health Centre (X-ray) and Thetford Healthy Living Centre (ultrasound and X-ray). Linked to our early intervention team (EIT), we also have in place a 24/7 service to provide personal care to patients in their home. Delivered by a reablement support worker, this forms part of a wider service, working to prevent unnecessary admission to hospital.

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

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

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

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

Our staff

We are one of the largest employers in Suffolk, employing 5,461 staff as of April 2024.

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

Our partners

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

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

The NHS Long Term Plan sets out a 'duty to collaborate' which was further developed in Working Together at Scale (2021), which requires NHS providers to be part of one or more Provider Collaboratives. In the context of finite resources, increasing demand and health inequalities, it is imperative for organisations to collaborate with partners, where this creates improved outcomes for patients and the population. This is supported by NHS strategy and policy, including the WSFT's strategy.

The WSFT and ESNEFT have been developing a collaborative approach over the past two years, including board to board workshops, joint working within functions including procurement, and mutual aid for specific clinical pathways.

The boards of both trusts have agreed a shared vision and principles for collaboration and adopted the recommendation to create some light-touch joint governance and a collaborative programme management office. This is being delivered by the Collaborative Oversight Group and the Collaborative Executive Group which will lead the strategy towards collaboration and integration and creating a supportive culture for this provider collaborative.

Going concern

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

1.2 Performance analysis

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

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

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

1.2.1 Performance management framework

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

Performance monitoring:

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

Governance framework:

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

Engagement and measurement:

- the NHS Fifteen Step Challenge focuses on seeing care through a patient or carer's eyes and exploring their first impressions. These include executive directors, non-executive directors (NEDs) 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 the National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics.

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

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

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

Core areas were inspected last in inspections in 2016, 2018, 2019, 2021 and 2022 (see charts).






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

In the most recent comprehensive inspection (report published in January 2020) inspectors said staff “*treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions they worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care*”.

The Trust's maternity services were inspected in April 2021, whilst the score for 'Well-led' did improve, it did not affect the overall rating of the service. The report noted that “*Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.*”

Last inspection: 13 April 2021






Report published: 22 June 2021

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

In 2022 we received a “Good” CQC rating for the Glemsford GP practice that is part of the WSFT, with the staff’s kindness and respect for patients highlighted.

Last inspection: 20 August 2022

Report published: 14 September 2022

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

The WSFT recognises that the CQC introduced a new single assessment framework (SAF) in 2023-24 and anticipates a future inspection within this new regime. The Trust welcomes the opportunities this will bring to demonstrate how the organisation is working towards achieving a ‘Good’ rating.

Our services

We provide a range of patient services:

Indicators	2023-24	2022-23	2021-22	2020-21	2019-20
Adult Community Services	305,306	279,026	260,237	239,900	247,700
Paediatric Community Services	89,035	85,637	84,885	69,491	77,269
Inpatient planned	3,330	3,476	2,407	1,722	3,475
Inpatient non-planned	38,234	33,977	32,708	29,623	32,374
Day cases	30,706	29,104	28,903	18,747	32,815
Outpatient attendances (inc. ward attenders)	288,181	267,015	281,162	234,464	271,316
Outpatient procedures	110,719	79,420	58,503	37,749	79,570
ED attendances	94,254	89,588	86,312	64,764	78,822

The 2021-22 activity started to return to pre-COVID-19 levels, and this has continued for the last two years. Emergency Department attendances and non-planned admissions are above pre-pandemic levels, when compared with 2018-19. The day case and outpatient activity (attendance and procedures) have all increased to be comparable with the pre-COVID-19 levels.

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

Our financial performance

Our reported position as at the end of 2023-24 was a deficit of £96.3m. This reflects a significant impairment of our main hospital building (£89.6m) which reflects the RAAC-related issues. Before this adjustment we would report a deficit of £6.6m which is in line with our revised plan for 2023-24.

	2023/24 £000s	2022/23 £000s	2021/22 £000s	2020/21 £000s	2019/20 £000s
Operating income	397,307	383,628	352,179	321,282	283,173
Operating costs	(383,973)	(363,322)	(336,573)	(307,751)	(272,245)
EBITDA* surplus(deficit)	13,334	20,306	15,606	13,531	10,928
Depreciation, dividend and other costs	(19,947)	(20,610)	(15,386)	(12,767)	(10,642)
Fixed asset impairments net of reversals**	(89,638)	755	(4,647)	(1,496)	(7,903)
Retained earnings	(96,251)	451	(4,427)	(732)	(7,617)

* 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.

Highlights of the year

First for Patients

Services and teams across the Trust aim to continue to provide excellent care to the people of our community and achieve results that have been recognised at a national level. Recently, the National Hip Fracture Database (NHFD) has rated WSFT as the top hospital in England and Wales for the care of patients with a hip fracture in 2023.

Not only is WSFT top in the country for meeting best practice criteria for patients treated for a hip fracture, but also received the highest figure ever recorded by the NHFD. Best Practice Tariff (BPT) was achieved for 96.4% of patients in all eight criteria measured on the database. The achievement builds on the team's previous successes, with many of the previous record figures in the national database also being set by the Trust.

Another national measure is the Sentinel Stroke National Audit Programme (SSNAP), a major healthcare quality improvement programme for stroke care. For the last quarter reported (at the end of 2023), our stroke team has maintained its high score of 90 as an Acute Admitting Stroke unit. Added to this, the team has upheld the highest 'A' rating for more than five years. For a small district general hospital with limited resources, that the colleagues providing these services continue to achieve these results is a truly impressive achievement.

The Getting It Right First Time (GIRFT) general surgery High Volume, Low Complexity (HVLC) review was commended as the best example of system working in general surgery reviewed so far by the national team and demonstrates the importance of collaboration in improving outcomes for patients.

Another positive set of results has come from the 2023 NHS Maternity Services Survey, part of the NHS Patient Survey Programme commissioned by the Care Quality Commission. The survey collects feedback given by service users cared for by maternity services during 2023.

This year's results highlight an upward trend of improvement in the quality and safety of the maternity care provided by WSFT. When compared to 2022's results, two areas saw statistically significant increases: ensuring patients can go home as soon as they would like to after giving birth without delay (from 6.2 in 2022 to 7.6 in 2023) and on the cleanliness of the hospital room or ward (from 9 in 2022 to 9.5 in 2023). The Trust scored highly for trusts across the region in 'care in the ward after birth' and 'feeding your baby'.

Members of our maternity team, led by lead clinical educator Georgie Brown, have marked the first anniversary of a programme that offers free basic life support and health advice sessions to parents and carers of newborn and young babies. More than 800 adults (accompanied by babies) have attended the events, both at the West Suffolk Hospital and recently at community venues, to unanimously positive feedback. Georgie and team recognised an unmet need and are giving their time and expertise to deliver a valuable service.

Another maternity colleague, Theresa Lancaster, education and practice development lead for maternity support workers (MSWs), was recognised for her outstanding contribution to the development of these staff with a prestigious award from the Chief Midwifery Officer for England (CMidO), Kate Brintworth. It was highlighted that Theresa's work helping to ensure her colleagues gained qualifications and attended study days, will improve the quality of care for women, babies and families.

There was a further focus on the value the Trust places on our health care support workers (HCSWs) when Sandra Austin, a member of our clinical education team, was presented with a Chief Nursing Officer for England award by Catherine Morgan, regional chief nurse. Sandra co-ordinates the Care Certificate programme, and has guided and supported more than 700 HCSWs from their arrival at the Trust, ensuring they feel valued, and reducing the number leaving the organisation from 24% to 10%.

Bridget Glynn, senior staff nurse in critical care services, won a coveted Cavell Star, which rewards exceptional care for colleagues, patients, or families. The award honours the memory of Edith Cavell, a British nurse who cared for injured soldiers of all nationalities during the First World War. Bridget's colleagues nominated her for the award to recognise her long and outstanding career at the West Suffolk Hospital, which over 40 years has included more than 37 in critical care. They cited how Bridget puts patients, families, and staff at the heart of everything she does, recognising the small things that matter, especially when experiencing end-of-life care.

The Trust held its first WSFT patient safety month in May, highlighting the processes and mechanisms in place which help promote a strong patient safety culture. During this month, the Patient Safety Incident Response Plan (PSIRP) for 2023-24 was launched, to help create a safer culture and drive improvement, and is a requirement under the national Patient Safety Incident Response Framework (PSIRF). This plan helps to show how the learning identified during safety investigations is translated into improvements. Also launched was a new patient safety education programme to help colleagues better understand how everyone has a role to play in fostering a strong patient safety culture.

Working closely with patient safety colleagues and other teams including human factors, and learning from deaths, the Quality Improvement (QI) team uses evidence-based methodology to help staff bring their improvement ideas to life. Since 2020, the team has gone from supporting 12 active projects to supporting 348, and also developed training to give Trust colleagues the tools to make positive changes that help improve the care we provide. With their support, teams have completed projects that have resulted in improvements in outcomes for our patients. For example, the team on F3 ward worked to better understand the link between the development of pressure ulcers and those who undergo significant orthopaedic surgery. By improving awareness and clinician confidence through training, the team decreased the number of patients who developed pressure ulcers following orthopaedic surgery by 43%, which will provide our patients with a much greater level of comfort during their recovery.

The work of the Trust's research team continues to be praised at a national and international level and has recently been acknowledged for its successes in recruiting people to take part in vital studies that will inform clinical practice for future generations.

A further reflection of the high-quality care we deliver to patients has been the national accreditation received by the pulmonary rehabilitation (PR) service. Part of our community and integrated therapies division, the PR team provides individualised care to support people with chronic lung or respiratory conditions to achieve their best quality of life and maintain their independence.

The introduction of the unscheduled care coordination hub (UCCH) by SNEE ICB has been a tool that symbolises the benefits of system working and delivering the right care, at the right time, in the right place. The WSFT urgent community response service can now attend appropriate calls – for example, falls - which would previously have been assigned to an ambulance. Not only has this reduced pressure on ambulance colleagues and the emergency department, but it has helped people stay at home by bringing care to them.

Another community service is the Trust's vaccination team, which has continued its dedicated work to protect Trust staff, system partners and the community of Suffolk from seasonal viruses. The autumn vaccination campaign started early in response to viruses increasing in the population, and the team achieved some of the best take-up rates for vaccination in the region. It has been widely praised for the service it offers to people with special needs, and those in economically-challenged communities, where health outcomes can be poor.

Also within the scope of our community services is the Community Equipment Service (CES) provided by Medequip on behalf of Suffolk and North-East Essex Integrated Care Board (SNEE ICB). West Suffolk NHS Foundation Trust (WSFT) is lead commissioner for this service, which earlier this year was visited by the High Sheriff of Suffolk Mark Pendlington, who saw for himself the system-wide provision of equipment that allows people to live in their own home and achieve their best quality of independent living.

Nicky Faulkner recently took on the new role of community diabetes nurse specialist, working with both the acute hospital diabetes team and the Trust's six integrated neighbourhood teams. Nicky is supporting community health colleagues to review patients with diabetes so they can receive the optimum standard of care.

During the several recent months of bad weather, our community colleagues were faced with negotiating significant flooding across the rural areas where they offer care to people at home. It is testament to their commitment to our patients that they battled through the floods – sometimes by tractor provided by “local hero” farmer Steven Brown - and took other steps amidst the torrential downpours and flooding to ensure patients' needs were met.

Engagement with our community included the Annual Members' Meeting in September. This event provided our foundation trust members and local community with an understanding about how the Trust is doing and the chance to learn more about child development from our expert consultant community paediatrician, Dr Ankit Mathur.

Other events which have taken place over the last year include the annual cancer forum in Bury St Edmunds in May, which provided support and information to cancer patients, their families, friends and support networks. Supported by My WiSH Charity and with well over 200 attendees, there were insightful presentations and interactive sessions throughout the day. In July, the Trust held its 'medicine for members' healthy heart event at Sudbury Football Club, sharing information on how people can take positive steps to look after their heart health.

My WiSH Charity continues to help WSFT enhance the quality and safety of the care it provides as well as supporting staff. It is heartwarming to see the support the charity receives, for example from the 14 teams who took on the annual Soapbox challenge, raising an incredible £23,178. In September, with considerable support from local businesses and donors, the charity was able to open the Butterfly Garden at West Suffolk Hospital for our end-of-life patients. This facility will make all the difference to those who are experiencing end-of-life care and their loved ones.

The work of the Trust, and these improvements, innovations and progress, are being made despite repeated industrial action. The strikes have brought significant disruption to colleagues both through the preparations beforehand and during strike days, and to patients through the postponement of appointments and procedures. Our colleagues have worked tirelessly through this difficult time and have showed each other compassion and respect. There have been outstanding examples of colleagues going above and beyond to ensure patients received safe care. This included retired consultants coming back to help look after patients, a GP providing inpatient care and also our colleagues from a wide range of professions who were key to keeping services safe.

First for Staff

Supporting and improving the mental and physical wellbeing of our colleagues is a key strategic priority for the West Suffolk NHS Foundation Trust. As well as the duty of care owed to our hard working, committed colleagues, striving to ensure people feel valued and happy at work has a positive effect on patient experience and improves staff retention.

The development of a People and Culture Plan for the Trust is aimed at ensuring there is an overall strategy driven by what our colleagues tell us - to support our people, we need to know how they feel about their working lives. The NHS Staff Survey is one of the largest annual workforce surveys in the world, offering a snapshot of what staff think across numerous areas of their working lives. The results of this anonymous survey are a cornerstone of how to understand where we need to focus our attention over the year ahead to ensure staff have the best possible experience at work.

Almost 2,500 colleagues completed the 2023 survey, which is equivalent to 46% of the workforce. Scores across all nine of the key areas improved compared to the 2022 findings, but while seven of these areas scored better than the national average, these scores were only slightly above average, showing there is more to do. The two areas which scored lower than the national average are around having 'a voice that counts' and feeling as though 'we are a team'. These are areas already being prioritised through the People and Culture Plan and will continue to be a priority in the coming year. One result that stood out was where WSFT sat in the region in relation to whether staff would 'agree' or 'strongly agree' with recommending this as a place to work. Here, the Trust ranked second in the east of England.

The survey also gave an insight into the experience of Trust colleagues from ethnic groups other than white, and the percentage that reported having experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months. That figure has increased from 31% to 34%, more than 12% higher than the rate for white staff, which stands at 20%, and of course is also too high. Experiencing or witnessing harassment, bullying or abuse, has a huge impact on colleagues and patients. Significant efforts have been made in the past year to improve the experience of people who are treated unequally while at work, due to characteristics such as race, disability or sexuality, and the Trust is committed to making this a fair and equal place to work for all staff.

To help achieve that, a strengthened organisational development and learning team has been established to improve the experience of all our staff, develop line managers and support colleagues to achieve their full potential.

In September 2023 a Learning Hub was launched as part of the Trust's first phase of the people and culture work, focused on the following areas:

- leadership and management
- coaching and mentoring
- health and wellbeing
- equality, diversity, and inclusion
- apprenticeships
- library
- induction and welcome for new starters.

We have welcomed a new Freedom to Speak Up Guardian (FTSU), and more FTSU champions have been trained, taking the message that speaking up is a gift, not a criticism directly to their teams. The network of

wellbeing champions has also been expanded. This is part of the NHS 'Safe Spaces' initiative for colleagues from overseas and supported by My WiSH charity. These champions are visible to anyone who may want to share concerns, worries, or just have a friendly conversation with someone who speaks their language, or simply has time to lend a sympathetic, non-judgmental ear.

This year, four staff networks have been launched to bring people together from across the organisation who have a shared interest in equality and inclusion for a particular group. As well as acting as a safe space and providing peer support, network members use their collective voice to influence positive change, support decision-making and provide a channel for communication between the senior leadership team and staff groups.

The networks are:

- the REACH network for all colleagues from a Black, Asian or other ethnic minority background, and allies
- the refreshed Disability Network aims to amplify the voice of colleagues who live and work with a disability, and allies in this area
- the Pride network is for all colleagues who are lesbian, gay, bisexual, trans or identify with other minoritised sexual orientations or gender identities, and allies
- the Parent and Carer network was launched in March 2024, and aims to support any colleague who has caring responsibilities.

With input from the Disability Network, the Trust was selected as a winner in the NHS England Equality, Diversity and Improvement Awards, under the category of 'assistive technology' and will be using the extra funding from the award to support the implementation of a digital assistive technology toolkit. This will enable staff members who have a disability to find out what digital means there are available to help them do their jobs and have a better experience at work.

The staff support psychology team, set up as a crisis response during the pandemic, is now a substantive part of the services the Trust provides to support the mental wellbeing of the workforce. This team of professionals, now expanded, and renamed the staff support and wellbeing service, continues to provide vital support to a significant number of colleagues, using evidence-based techniques and pathways.

The partnership between WSFT and Abbeycroft Leisure (ACL) has been extended for a further year, giving all staff free access to all the facilities and activities at any ACL centre in Suffolk. Providing a way to access the many benefits of being more active, this investment has received overwhelmingly positive feedback from colleagues making use of this offer.

The vaccination team set up during the pandemic now has a permanent base at the West Suffolk Hospital, and this year provided the protection of free COVID-19 and seasonal flu boosters to thousands of staff, as well as people in communities across Suffolk. Understanding the reality of working lives in the NHS, the team took a flexible and responsible approach to the seasonal campaign, going where – and when – they were needed by our teams.

In summer 2023, with the support of the My WiSH Charity, the Trust launched Schwartz Rounds, an initiative aimed at supporting staff wellbeing and improving patient care. There has been excellent feedback for these structured forums, which allow colleagues to discuss the emotional and social aspects of working in healthcare.

In December 2023 there was cause for celebration when the clinical education team was awarded gold in the NHS England Pastoral Care Quality Award for support workers. The achievement of this gold award, which has only been given to two NHS trusts in the East of England, is testament to the commitment we have to support our healthcare support workers and shows the hard work the team puts into looking after and valuing this important group of colleagues.

In February 2024, various teams came together to organise the annual Love Yourself Week, which aims to encourage people who work in this demanding service to focus on their own health and wellbeing. The week included a partnership with The Poetry Pharmacy, and a 'walk with words' exhibition displaying poetry representing the trials and tribulations of a working life in the NHS.

Members of the clinical education team have also been awarded the National Preceptorship Gold Interim Quality Mark Award, recognising their work in supporting newly-registered nurses, midwives and allied health professionals (AHPs). During the year, the team has launched the preceptorship champion role, training experienced staff to promote the value of preceptorship and support implementation where they work.

The same team has now welcomed more than 50 cohorts of nurses and midwives from overseas, all of whom need to pass the Objective Structured Clinical Exam (OSCE) to be able to register to practise in this country. Thanks to their efforts, the Trust has a 100% OSCE pass rate, an astonishing achievement. Across the WSFT workforce one in five of our staff, and one in four of our nurses, have come to us from another country to care for our patients or fulfil roles in our supporting teams, and they are hugely valued.

The drive to 'grow our own' highly-skilled, educated and qualified workforce for the future continues as another important element of our strategy. This year has seen an increase in the number of colleagues undertaking our apprenticeship programmes, from healthcare support workers who want to become registered nurses, to managers taking senior leader apprenticeship at Masters level. As well as their own hard work doing academic studies alongside their jobs, apprentices are mentored by colleagues – this is a real commitment from everyone involved that brings enormous benefits for the Trust.

One element of the People and Culture Plan is a review and refresh of the reward and recognition strategy the Trust has in place for staff, and initial steps have included a survey of views about how people would like to see colleagues' efforts appreciated. Our existing long service awards, and peer-nominated Putting You First awards have remained in place while the new strategy is developed. The loyalty shown to the Trust and the NHS from people who spend their working lives here is humbling – as are the stories that come to the executive team from the nominations for Putting You First awards.

Awards are also part of the annual volunteers' tea party which this year was attended by more than 100 of the people who work alongside our staff providing so much valuable service. The party is a small gesture of gratitude for everything they do and includes the presentation of long service awards. Twenty-five volunteers received awards this year, people who between them have given more than 400 years of selfless service to our Trust.

Across the Trust we have our valued administrative staff, porters, cleaners, estates and catering colleagues – to name just a few of the people without whom our Trust simply could not function. Two of our chefs achieved national recognition this year, when Connor Gutsell and Glen Stone cooked up a storm at the NHS England Chef of the Year competition and in doing so secured fourth place. Their hard work and commitment, and the support of their catering department colleagues, exemplify the team spirit that is a hallmark of our Trust.

First for the Future

The new healthcare facility on the Hardwick Manor site in Bury St Edmunds, which will replace the existing West Suffolk Hospital, is of course a keynote project. There has recently been significant progress in the exploratory and preparatory works ahead of the construction phase. Archaeological trenching was completed in early 2024, and buffer trees are being planted at the site to reduce the visual and sound impact of the new facility and are an important part of the enabling works to prepare the site. The New Hospital Programme minister, Lord Markham MBE and Suffolk MPs Jo Churchill and James Cartlidge came to the planting of the first buffer tree. This was an exciting step forward, meaning the Trust is on track to deliver this new facility for 2030, working with New Hospital Programme colleagues and system partners as plans develop.

Earlier in the year, as part of the ecology compensation strategy, approximately one hectare of turf containing rare fungi was moved from the Hardwick to two new sites with identical soil DNA to conserve it. The success of this move is looking positive with early signs of the fungi thriving.

The team continues to co-produce the designs for the scheme. Engagement with staff, patients and members of the community regarding digital technology in the new hospital is now complete. The research will help bring the 'digital first not digital only' strategy to life and understand the future needs of those who will work within and use our hospital.

Construction of the new Newmarket Community Diagnostic Centre (CDC) at the town's community hospital is progressing. It is on track to see its first patients before Christmas 2024, with concrete groundworks being completed and the steel structure expected to be going up this Spring. This facility will create additional diagnostic capacity, providing around 100,000 tests a year, which will help us reduce health inequalities and waiting times while giving local communities access to the care they need as quickly as possible.

Diagnostic tests at the CDC will include magnetic resonance imaging (MRI), computed tomography (CT), X-ray, ultrasound, heart scans and blood tests. As a result of the 123 solar panels that will be installed at the community hospital as part of the project, WSFT has surpassed its ambition to generate 10% of the site's energy renewably, with current predictions putting this at a minimum of 46%.

The Trust's virtual ward is an important route to allow patients to be discharged from hospital earlier, to continue their recovery at home or in another care setting or prevent them from having to stay in hospital in the first place. In line with the strategic plan for the virtual ward, it has moved into the community and integrated therapies division.

The virtual ward began in the medicine division to ensure it engaged effectively with acute services and built the important relationships which drive awareness and referrals. Now that it has been caring for patients for more than one year, it will fully integrate into the community division so that closer working can be achieved with community teams, and also primary and social care partners.

The virtual ward is a totally new way of working, which in its first year has saved more than 6,600 bed nights in our hospitals. It will continue to grow and develop into a significant service to manage current and future demand.

The drive to provide and improve healthcare across west Suffolk reaches well beyond the boundaries of the bricks and mortar of the hospitals, centres and homes in which services are delivered. As part of the West Suffolk Alliance, a collaboration of health and care service organisations committed to working together to improve the health and care system for everyone in west Suffolk, we are actively going out into communities to help people look after and improve their health.

One example is a pilot project on the Howard Estate in Bury St Edmunds focusing on identifying those most at risk of cardiovascular disease and helping residents manage high blood pressure. The pilot sees GP surgeries contacting residents whose health records show that they either have, or are at risk of, high blood pressure. In the future it is anticipated that residents will be able to have blood pressure checks in places such as the local community centre, bringing healthcare even closer to people's homes. Working to support the prevention of ill-health and reducing health inequalities are important parts of the Trust's strategy, to improve the health and wellbeing of local people, reduce demand on services and ensure that everyone has the access to the healthcare they need and deserve.

As this year ends, the Trust is preparing to mark 50 years since the West Suffolk Hospital was fully opened. The focus will be on the part the hospital, and the wider Trust, plays in the heart of west Suffolk and beyond, underlining its importance to our community. The story of the West Suffolk Hospital is a story of service and commitment from thousands of staff, and their story continues as we look to the next 50 years.

1.2.3 Quality and operational performance

Quality priorities for 2023-24

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

Delivering our strategy

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

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

Priorities for 2024-25

- to deliver measurable improvements in safe care through implementation of our patient safety strategy
- to reduce inequalities in experience for service users.

Measuring our progress and providing assurance

Safe and high-quality care

- to improve the quality and timeliness of discharge summaries to ensure appropriate communication at the point of transfer of care – Q1 data will be used to establish a baseline to determine target for March 2025
- to reduce rates of hospital and community onset healthcare associated *C. difficile* infection against the 2023-24 baseline of 67 cases.

Experience of care

- development of personalised care and support plan datasets into e-Care, including integration of the patient profile by March 2025
- increase of 10% in recording of protected characteristics on patient records
- implementation of a reasonable adjustment policy to support service access by March 2025
- increase of 10% in reasonable adjustment needs recorded on e-Care by December 2024
- improvements to booking and waiting procedures for those with reasonable adjustments by March 2025
- accessibility improvements to web content and software by March 2025
- assessment/completion of the Equality Delivery System to provide better working practices and environments by March 2025
- accessible guides and improvement plans for all Trust sites by September 2024.

Performance against 2023-24 priorities

The quality priorities agreed for the year 2023-24 were driven by our strategy and set out key improvements we aim to deliver and the measures that we will use to understand progress and success. Recognising that the strategy is a long-term plan, the expectation is to demonstrate progress the priorities as described in this section.

Delivering our strategy

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

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

Priorities for 2023-24

Quality priority 1 - to deliver measurable improvements in safe care and confidence to raise concerns through implementation of our patient safety strategy by March 2024

Quality priority 2 - to deliver measurable improvements in experience through the implementation of our experience of care strategy by March 2024.

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

The following describes progress against our agreed delivery measures.

1.1 Increasing percentage of relevant staff completing the patient safety syllabus by March 2024

The national patient safety syllabus was devised following the publication of the national patient safety strategy and applies to all NHS employees. The syllabus outlines a different approach to safety, emphasising a proactive approach to risk and introducing systems thinking and human factors. The training has five levels which are in development. We mandated level 1- essentials for all staff on the NHS Electronic Staff Record (ESR) during Q1.

Measured against this new programme 91% of our staff have undertaken the training and we will explore further whether we mandate level 2 for clinical staff through the mandatory training steering committee. Our patient safety specialists are currently studying levels 3 and 4 at Loughborough University.

1.2 Increasing percentage of relevant staff completing the patient safety education programme by March 2024

Our in-house patient safety education programme, to train staff to use systems thinking and apply this in response to safety events at our organisation, was launched during patient safety month in May 2023. There are currently four modules available to staff with more in development. More than 150 staff have now attended one of these courses since its launch in 2023. We are working with the digital team to migrate this training onto Totara (our online learning hub) to ensure this is the most effective form of delivery and enable access to staff who may not be able to attend the scheduled training session dates.

Whilst it is considered important that all staff have access to the training, we are reviewing training requirements to signpost staff who undertake patient safety investigations to ensure they are appropriately trained. This is in addition to the mandated patient safety syllabus level 1 and the introduction of the training for investigators via Radar Healthcare. Radar replaced our incident reporting system, Datix in April 2024.

1.3 Number of patient safety partners (PSP) in post by March 2024

We have not successfully recruited into the PSP role for WSFT, however we work closely with the PSPs from the ICB, who regularly attend our emerging incident review meetings, and support our safety and quality committees and initiatives, for example, Call 4 Concern © which was introduced across the WSH on 1 May 2024. It is recognised that the patient voice in this forum is an important addition, so we are grateful to our

system partners for engaging with us. We will continue to actively pursue the ambition to have WSFT PSPs over the course of the next year. It is recognised, regionally and nationally that recruitment to these posts has been variable so we are linking with other organisations who have been successful to learn from their successes.

1.4 Coproduce the qualitative and quantitative measures we use to gauge and develop our safety culture by March 2024 e.g. temperature gauge and implement regular monitoring

We have reviewed the measures associated with duty of candour and developed an audit approach, which has produced encouraging results, and is reported quarterly to the patient safety and quality governance group (PSQGG). The move from a compliance-driven metric to one which encompasses the qualitative aspect of duty of candour is the direction in which we will continue and embed a safe culture, where people are confident to have open and candid conversations.

We are currently working on developing a suite of metrics to measure safety, linking to the new CQC single assessment framework quality statements for safe. This will be reviewed and agreed via the PSQGG and form part of the quarterly patient safety update to the Board's improvement committee.

The patient safety team is also working closely with organisational development and human resources colleagues to review and measure implementation of 'Reviewing patient safety culture – a practical guide', published by NHSE. This will be reported to the people and culture committee.

1.5 Implement a programme of shared learning events, including an annual safety summit by March 2024

The patient safety team launched a safety summit in September 2023. Using the feedback from this we have revisited what learning looks like and how best to share this across the Trust. We are progressing with delivery of our third safety summit in 2024-25. This will be a workshop forum to progress safety improvement initiatives, which better aligns with the national Patient Safety Incident Response Framework (PSIRF) principles. We have also produced a quarterly shared learning analysis report to complement our quarterly thematic incident analysis report, to be shared with specialist committees and divisions.

1.6 Deliver an increase in user access of the e-Care* patient safety dashboard to support high standards of safe care by March 2024.

We are continuing to review our dashboard indicators to ensure the data is accurate, relevant and used to measure quality at specialist committee and divisional levels. Options include creation of a new report to replace the current safety report. This is dependent on transition and development of the Trust's new data warehouse to generate these reports.

2.1 Evidence of learning by March 2024 - 90% of complaints resolved within agreed timeframe, 90% of improvement actions from complaints/feedback implemented to timeframe and implement a programme of shared learning events

97% of all complaints due in 2023-24 were responded to within their agreed timeframes. The experience of care and engagement committee has developed a themed bi-monthly meeting focusing on a specific learning event or trend to enable full discussion and assurance. The patient experience team has also developed a suite of patient and family stories to enable reflection and learning which are also available on Totara (e-learning platform) and on the staff intranet.

2.2 Equality delivery system assessments of accessibility and inclusivity of patient services by March 2024 - more than two equality delivery system assessments completed with associated quality improvement plans

A full organisational equality delivery system (EDS) assessment was undertaken and submitted to NHS England in 2023-24. An action plan has been identified and delivery is monitored through the Belonging to the NHS Group.

2.3 Parliamentary and Health Standards Ombudsman (PHSO) Complaints Standards updates - 100% compliance with recommendations and completion of action plan

During 2023-24, two complaints were referred to the PHSO, both investigations are still ongoing. This is compared with three in 2022-23. One of these complaints was referred to both the PHSO and Local Government and Social Care Ombudsman (LGSCO). The outcome of the LGSCO was that the complaint was not upheld however, the PHSO investigation is ongoing. One complaint which was referred to the PHSO in 2022-23, the investigation was concluded in 2023-24 and was found to be partially upheld. Action has been taken in response to the PHSO feedback, including ongoing improvements to fluid balance charts and the patient record system.

2.4 Patient story programme by March 2024 - all open Board meetings include presenting patient or staff story and these are published on the staff intranet for training and reflection

All Trust Board meetings have received staff and patient stories covering a range of topics. Stories for the rest of the year are scheduled.

2.5 Public engagement programme measures by March 2024 - patient experience/customer service training programme by March 2024 - 50% of reception/patient-facing/telephone administrative staff trained and >80% recommender rating in training evaluation.

Due to capacity demands we are currently unable to meet this priority fully. However, the complaints team is conducting a quality improvement project to develop capacity. Updates from the project will be monitored by the experience of care and engagement committee and assurance provided to the involvement committee of the Board.

Other quality indicators

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on a monthly basis. These include priorities identified by patients and staff, issues arising from national guidance and research, and other stakeholders such as SNEE ICB. Performance against agreed indicators is monitored by the Board on a regular basis. A range of nationally-mandated quality indicators is reported in Annex B.

National standards

	2023-24 Target	2023-24 Actual	2022-23 Actual	2021-22 Actual	2020-21 Actual
C. difficile - health care associated ¹	49	67	52	37	27
18-week maximum wait from point of referral to treatment (patients on an incomplete pathway)	92%	52.9%	63.8%	64.6%	57.2%
Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge ²	76% (Mar '24)	73.95%	-	-	-
62-day urgent GP referral-to-treatment wait for first treatment - all cancers	85%	82.8%	65.3%	71.5%	75.0%
62-day wait for first treatment from NHS cancer screening service referral	90%	83.3%	85.2%	80.7%	94.2%
Two-week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	81.1%	70.6%	66.0%	71.5%
Two-week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	96.9%	52.1%	35.2%	94.3%
Maximum six-week wait for diagnostic procedures	95% (by Mar '25)	68.2%	60.1%	67.1%	49.8%

- 1 From 2022-23 target and performance includes both hospital and community onset healthcare associated cases, prior data only includes hospital associated cases
- 2 WSFT piloted new emergency department reporting standards between 2018-19 and 2022-23 and therefore did not report performance against this standard during this period.

We recognise the underperformance in a number of areas and this has been the subject of scrutiny at Board, assurance committees and governance groups. Plans to achieve the agreed standards for 2023-24 are monitored and reviewed. Improvement in *C. difficile* performance has been identified as one of our quality priorities for 2024-25.

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

There has been significant progress in reducing the elective waiting times for patients over 2023-24 including the elimination of 104-week waits. Following positive progress throughout the year, the number of 78-week and 65-week waits were higher than revised trajectories at the end of March 2024, this was impacted by industrial action during February.

The 2023-24 planning guidance requirement to eliminate elective waits of 65 weeks or more has been extended by six months to be delivered by the end of September 2024. For WSFT, this will require the end of March backlog of 407 patients to be cleared, as well as patients whose waits are not yet at 65 weeks but will be by the end of September deadline. This will require additional activity within the sub-specialty of urogynaecology. This will need to be balanced against recovery within surgical specialties and plans to mitigate this include a potential combination of outsourcing, insourcing and additional internal activity to deliver.

The expectation of previous years' planning guidance to reduce outpatient follow ups has been replaced by a new productivity metric. This states our integrated care board (ICB) must increase the proportion of outpatient attendances that are either a first attendance, or a 'clock stopping' follow-up attendance including a procedure, to 46.2%, from the first six months of 2023-24 baseline of 44.5%. It is anticipated that this can be achieved from a combination of reducing follow-ups with no procedures, swapping this capacity for either first attendances or procedure clinics. It will be critical to ensure that all activity is counted and coded correctly so that the reported position is accurate.

The follow-up reduction will be modelled as taking effect in Q2, as transformation schemes will be delivered to support this.

The two-year objective of 95% of diagnostic tests delivered within six weeks by March 2025 is reiterated in this year's planning guidance. Given that all diagnostic modalities at WSFT committed to the delivery of this last year and there have been no material impacts to demand or capacity, the Trust is recommitting to this objective in planning for 2024-25. The Community Diagnostic Centre (CDC) at Newmarket, expected to open by Christmas 2024, will provide a significant step change in some modalities, but further activity increases from existing recovery plans will also be required, particularly in endoscopy where there will be no additional CDC capacity.

The strong performance against the cancer ambitions for 2023-24 of 75% against the 28-day Faster Diagnosis Standard, and reducing the 62-day backlog, will support delivery of the 2024-25 objectives of 77% against the Faster Diagnosis Standard; and 70% against the combined 62-day standard (urgent suspected cancer, screening and consultant upgrade referrals).

Services and pathways will need to build on improvements and transformation work already completed, particularly to respond to increases in demand across the high-volume pathways in suspected breast, lower gastrointestinal tract and skin cancers. Consideration will be given as to how transformation which has been delivered through non-recurrent East of England Cancer Alliance service development funding will be sustainably achieved.

Urgent and emergency care

Having reintroduced the 4-hour standard for the emergency department (ED) in May 2023, WSFT has demonstrated variable performance with significant progress in March, ending the year with 74% against the standard of 76%.

The headline metric for urgent and emergency care (UEC) will continue to be the 4-hour standard, which will increase from 76% to 78% by March 2025. Additional indicators of average ambulance handover times will need to be maintained below 30 minutes and the number of patients waiting 12 hours or more in the Emergency Department (ED) will need to be reduced from current levels.

Key to delivery and further improvement will be consolidating and continuing workstreams from 2023-24 plans, including those funded by the UEC capacity and discharge fund streams, alongside new developments such as the six-month trial of a minor emergency care unit. Within the department, lessons learned from the additional senior operational and clinical leadership support in March 2024 will be captured and embedded within an evolved recovery plan. This additional support may need to be deployed again should performance significantly deviate from trajectory.

Community and primary care

The Trust consistently achieves the 2-hour urgent community response standard within community services. It has been challenging to monitor consistent primary care access performance data in relation to the Trust's GP surgery at Glemsford. The Trust has committed to meet all requirements of the 2024-25 priorities and operational planning guidance, including:

- improve community services waiting times, with a focus on reducing long waits (NB it is anticipated that more specific guidance will be released later in the year)
- continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

Stroke services

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

Our stroke team has retained its top-grade A ranking for more than five years. SSNAP is a major national healthcare quality improvement programme based in the school of life course and population sciences at King's College London. It reviews data from hospitals across the country as part of the SSNAP, assessing stroke care against 43 key indicators.

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

Incident reporting and learning

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

The Trust uploads patient safety incidents to the National Reporting and Learning System (NRLS). In 2023-24 this national system was replaced by the new Learn from Patient Safety Events (LFPSE) however WSFT, in common with many other providers, had not yet transitioned to the new reporting system at the time of this report. We envisage that LFPSE reporting will be implemented in 2024-25 as part of a wider project to change our electronic risk management system from Datix to Radar Healthcare.

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

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

During 2023-24 the total number of patient safety incidents reported was 11,112. From that total number there were 11 patient safety incident investigations (PSIIs) commissioned. Many other incidents were subject to another method of review (such as 'after action review', patient safety audit or 'structured judgement review'). This is part of the overall principles of PSIRF to enable focus on improvement following system-based learning to improve patient safety for the future. The 11 PSIIs were commissioned in 2023-24 according to the following (local and national) categories from our PSIRF plan.

Local	1C. Barriers to effective discharge due to issues in coordination of system	1
	2C. Diabetes, problems with the clinical care / management of diabetic patients when diabetes is not the primary reason for admission to service / hospital	1
	4C. Barriers to effective inclusivity	1
	6C. Identified increase in incidence of subject of theme which has potential for harm	2
National	7C. Never Event ¹	2
	8C. Deaths more likely than not due to problems in care ²	4

¹ Equipment that detached and was retained in the patient during a procedure and an injection administered in the wrong toe web space

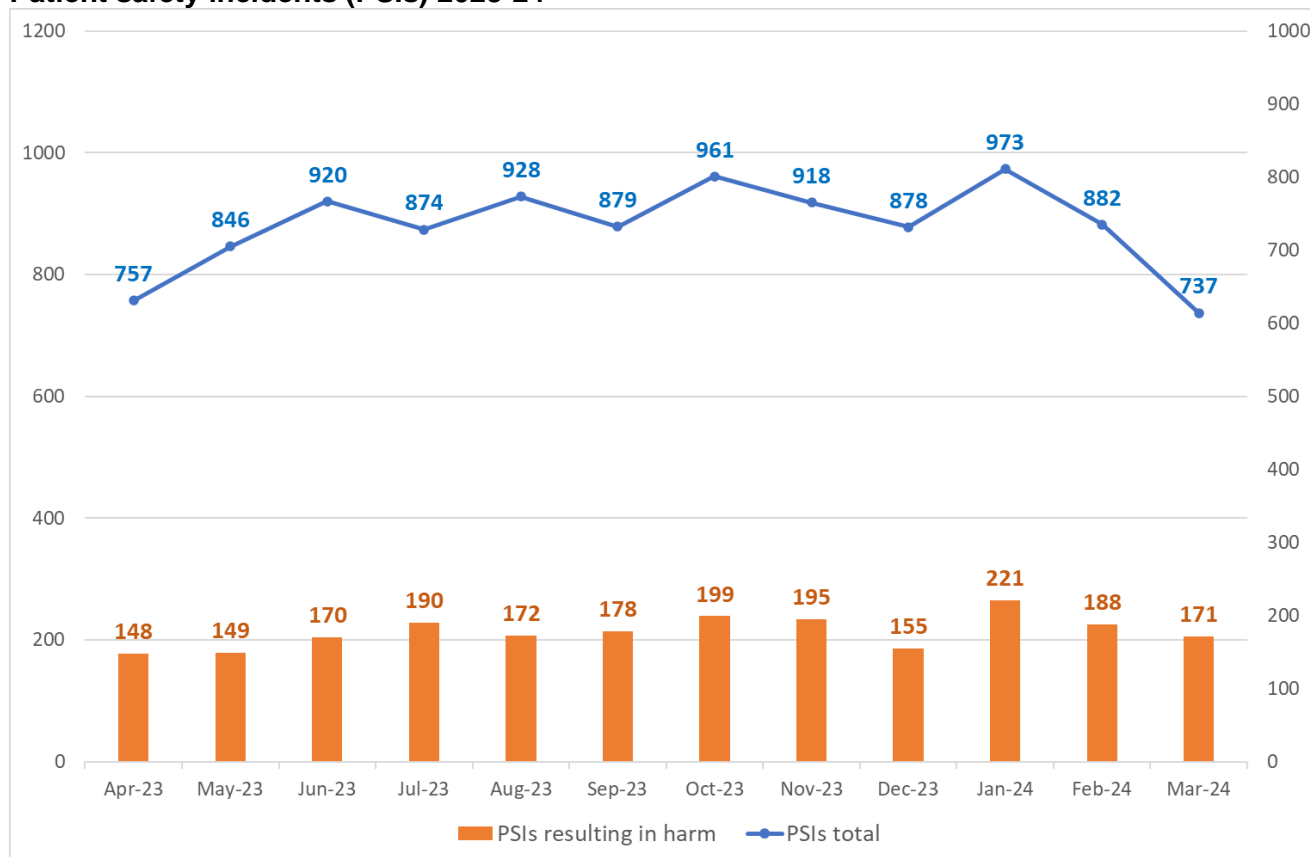
² Late/missed diagnosis (2), accessing specialist prescribing advice and monitoring.

Patient safety incidents reported

The chart below shows how many patient safety incidents were reported in 2023-24. The organisation reviews this data on a monthly basis and recognises the high reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents.

A slight drop in March was unexpected and, when further reviewed, was mainly due to a reduction in reporting of pressure ulcers. This is being kept under review to see if it is a continued trend.

Patient safety incidents (PSIs) 2023-24



Source: Datix

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

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

AFIs identified from the five PSII reports completed in 2023-24 have included the following examples:

- standardised processes for results review across our organisation to enable the right clinician to review test results at the right time
- opportunities to support staff in a more responsive way when they are delivering care and treatment in escalation areas (i.e. additional areas opened at times of high demand)
- standardised practice for checking implants across the orthopaedic team so that all staff in the team are clear what to expect
- improvement opportunities by participating in the National Audit for Time Critical Medications in the emergency department.

In addition, wider learning can be gained from thematic review of common events such as pressure ulcers and falls, which feed into quality improvement programmes overseen by the specialist teams.

Duty of candour (DoC)

DoC applies to notifiable patient safety incidents. A notifiable patient safety incident is an incident which is unintended or unexpected and in the reasonable opinion of a healthcare professional, already has, or might result in death, or severe or moderate harm to the person receiving care. This is a legal requirement requiring NHS organisations to:

- have a face-to-face discussion and offer an apology to the patient or relevant person following a safety incident resulting in moderate harm or above

- provide written communication following the face-to-face discussion with the patient, to include: an account of the known facts about the incident, details of any enquiries to be undertaken, the results of any enquiries into the incident and an apology.

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

In 2023-24 WSFT introduced a new DoC audit which enabled a greater focus on the quality of the DoC process, rather than a simple proxy measure of 10 working day timeliness (the national target is 'as soon as reasonably practicable').

Learning from deaths

During 2023-24, 957 people who were inpatients at WSFT died (of which 950 were adult patients, eight of those were people with learning disabilities and five had a severe mental illness, one was a neonatal death, and six were stillbirths). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 263 in the first quarter (of which 260 were adults, three were people with learning disabilities, none had a severe mental illness, none were neonatal deaths, three were stillbirths)
- 216 in the second quarter (of which 214 were adults, two were people with learning disabilities, three had a severe mental illness, none were neonatal deaths, two were stillbirths)
- 260 in the third quarter (of which 259 were adults, two were people with learning disabilities, one had a severe mental illness, none were neonatal deaths, one was a stillbirth)
- 218 in the fourth quarter (of which 217 were adults, one a person with learning disabilities, one a person with a severe mental illness, one was a neonatal death, none were stillbirths).

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

- Diagnostic:
 - deaths of patients with a severe mental health illness
 - deaths of patients with a learning disability
 - deaths in a service specialty, particular diagnosis, or treatment group where an 'alarm' has been raised (this is identified through the national Summary Hospital-level Mortality Indicator (SHMI) reporting portal). There were none of these identified in WSFT in 2023-24.
- System focused
 - deaths where learning will inform the provider's existing or planned improvement work. In WSFT we have a current improvement programme for end of life care
 - death within 30 days of discharge from hospital. We review a representative sample percentage of these deaths.
- Safety learning
 - deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision. This includes referral from our patient safety team.
 - deaths in areas where people are not 'expected' to die, such as during elective surgery.

In addition, each trust will identify local priorities on which to undertake SJR reviews. In this reporting period our medical examiners were asked to highlight any cases for an SJR review where:

- staff did not recognise that a patient was end of life. This can mean that patients continue to receive interventional care such as injections or scans which are not necessary and can impact on their comfort
- there were any delays or missing results (e.g. X-rays or blood tests) and/or not taking an action following a diagnostic result.

Stillbirths and neonatal deaths are reviewed locally using the Perinatal Mortality Review Tool (PMRT) or through external review by the Health Services Safety Investigation Body (HSSIB) (for cases meeting the notification and reporting requirement definitions of Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE)).

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

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

The sum of PSIIIs as well as PMRTs and HSSIB referrals in our maternity services have been used to provide the data for the number of investigations.

The Trust records and reviews deaths of patients with a learning disability and patients with a severe mental illness. Feedback from these reviews to enhance wider learning is included as scheduled agenda items in the mortality oversight group meetings in 2023-24. This includes feedback from external reviews to incorporate wider national learning.

The Trust records and reviews deaths of patients in maternity services including stillbirth and neonatal death (there were no deaths of women during or immediately following delivery in 2023-24). Feedback from local HSSIB reviews and wider learning from the national HSSIB maternity reporting programme are included in the maternity programme of improvement.

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

Learning from reviews of adult deaths has identified a number of themes:

- inability to fast-track discharge enabling those who wish to die at home to do so. The End of Life group has been kept fully informed of this as an emerging theme and are working to improve the early recognition of dying patients who wish to go home and expedite this discharge
- impact of reduced staffing and increased workload on the ability to perform timely nursing assessment has led to an educational package being developed for nursing assistants and improvement work. This encourages collaboration between nursing assistants and registered nurses when reviewing patient observations
- delayed recognition that a patient is reaching the end of their life: this has led to targeted education and a Grand Round focusing on end-of-life conversations. The Trust is adopting the recommended summary plan for emergency care and treatment (ReSPECT) process from the National Resuscitation Council and online learning is now available.

A new theme identified in 2023-24 reporting period was:

- Patients spending an extended period of time in the Emergency Department (ED), meaning that some patients who would previously have been admitted and died in an inpatient areas, stayed in ED. The ED team is being supported to prioritise patients who are in their final hours or days.

It was identified that a small number of stillbirths took place when the mother was from a Black, Asian or another ethnic minority (BAME). These cases, while small in number, are higher as a percentage of stillbirths than the equivalent percentage of BAME mothers in total. No common theme was identified however it is recognised that this has been noted as a national concern within the findings of the most recently issued MBRRACE-UK report, the recommendations of which have been reviewed and a responded to.

An external review of the local cases has been undertaken to provide additional independent scrutiny. Actions from the recommendations of the thematic review are being implemented. WSFT maternity services will monitor implementation to ensure that these are completed in a timely manner, are effective and have the desired effect on quality and safety.

Complaints management

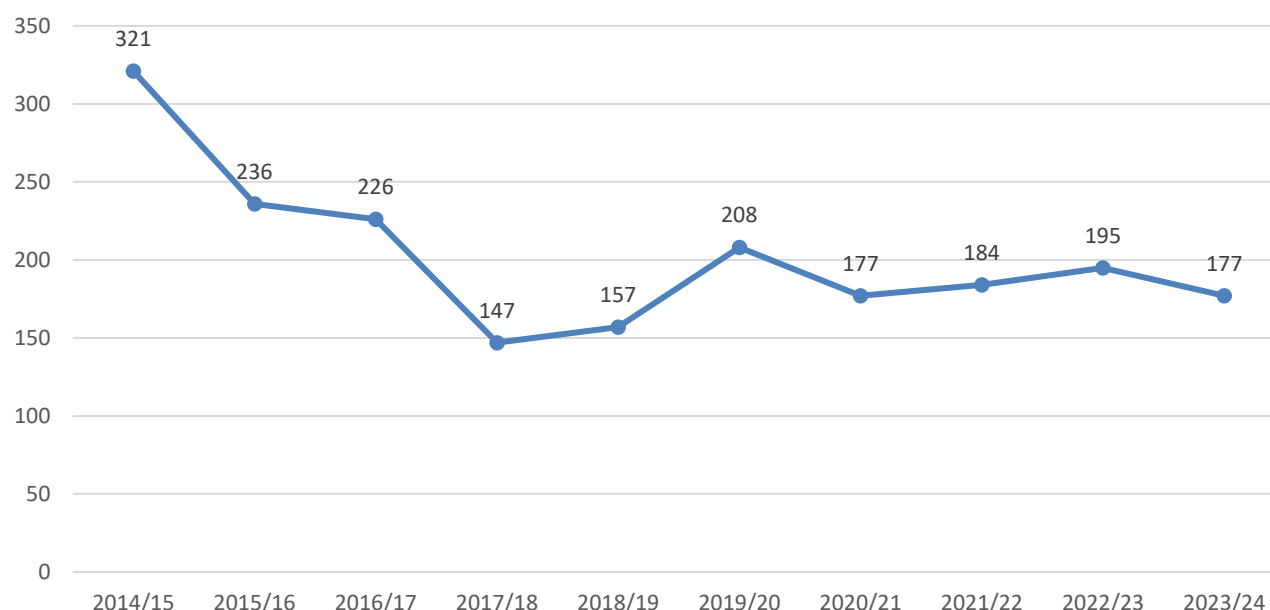
WSFT is committed to providing an accessible, fair and effective means of communication for anyone who wishes to express their concerns with regard to the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the NHS Complaints Standards as published in December 2022 by the Parliamentary and Health Service Ombudsman (PHSO).

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

Examples of learning are detailed below. Themes and lessons learned are also reviewed at the experience of care and engagement committee and by the involvement committee.

WSFT received 177 formal complaints during 2023-24. The Board monitors complaints and learning each month as part of the quality reporting arrangements.

Number of formal complaints received



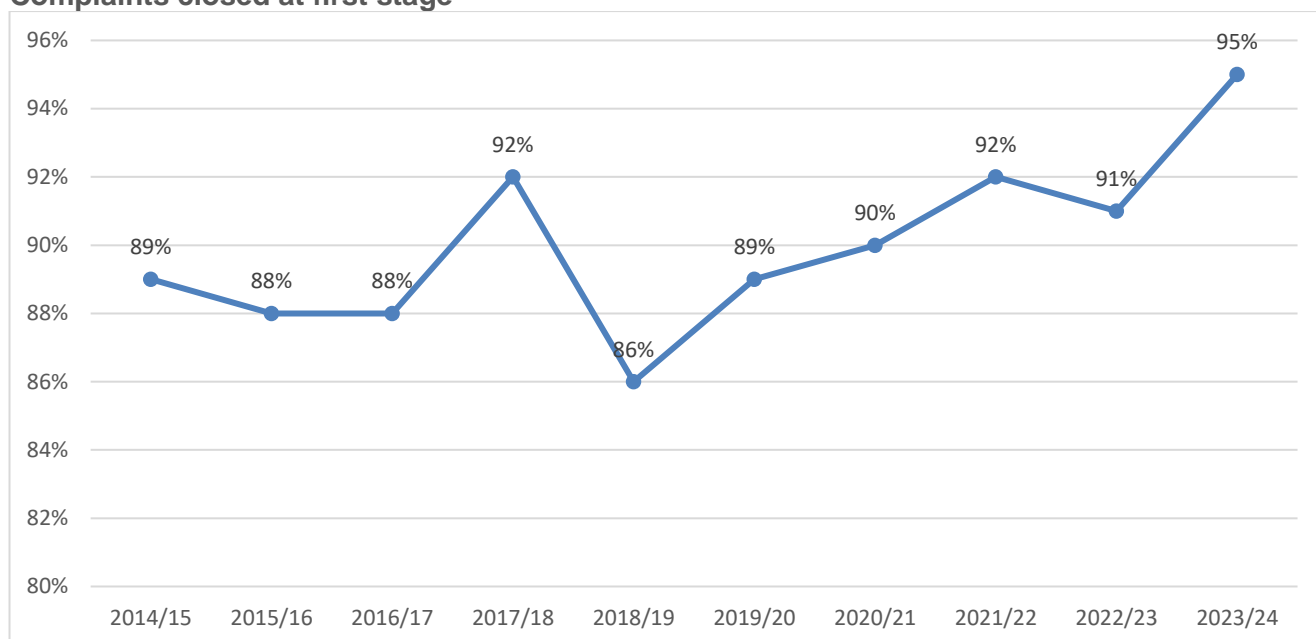
Source: Datix

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

In 2023-24 the Trust successfully resolved 168 complaints at the first stage, with nine investigations escalating to second stage throughout the year, reflecting a 95% first-time resolution rate.

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

Complaints closed at first stage



Source: Datix

Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO or the Local Government and Social Care Ombudsman (LGSCO) for an independent review. During 2023-24, two complaints were referred to the PHSO, both investigations are still ongoing.

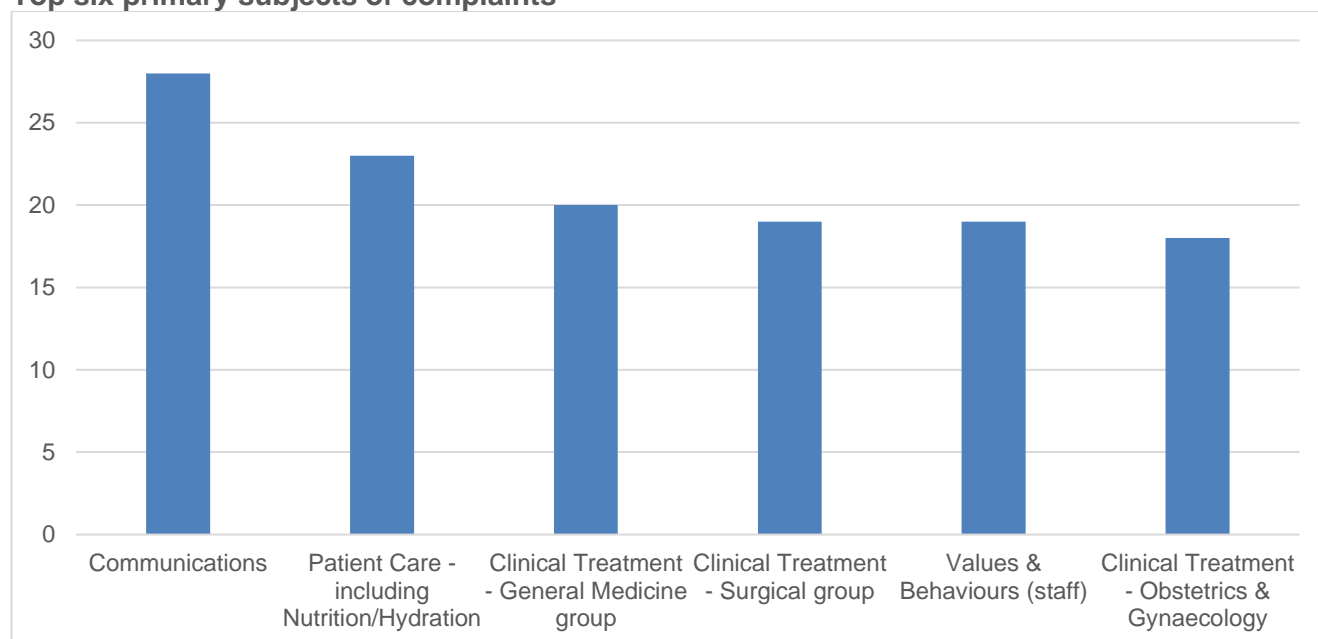
One of these complaints was referred to both the PHSO and LGSCO. The outcome of the LGSCO was that the complaint was not upheld however, the PHSO investigation is ongoing.

One complaint which was referred to the PHSO in 2022-23, the investigation was concluded in 2023-24 and was found to be partially upheld.

During 2023-24, two complaints were referred to the PHSO compared to three cases in 2022-23. Both investigations of the complaints that have been referred to the PHSO are still ongoing.

With only two complaints being referred to the PHSO in 2023-24, this further demonstrates the thorough investigations completed at local level.

Top six primary subjects of complaints



Source: Datix

The numbers identified in the chart above list only primary concerns; many complaints have multiple categories. Four out of six of the top categories have remained the same since the previous financial year; however, clinical treatment for the general medicine group has replaced clinical treatment for ED services. Clinical treatment for obstetrics and gynaecology has also become one of the highest subjects for formal complaints in 2023-24.

Communications is the top category of concern and the number of complaints under this subject have increased from 18 in 2022-23 to 28 in 2023-24. Patient care complaints have decreased from 32 in 2022-23 to 23 in 2023-24. Clinical treatment within the surgical group has increased from 15 in 2022-23 to 19 in 2023-24.

Whilst clinical treatment within the general medicine group did not feature in the top categories of concerns for the previous financial year, it has remained the same, with 20 formal complaints being listed under this subject in both 2022-23 and 2023-24.

Clinical treatment in obstetrics and gynaecology was also included in the top categories for 2023-24 following an increase of complaints under this subject, from 18 in 2022-23 to 19 in 2023-24.

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

- actions have been completed to improve communications between ward staff and relatives
- maternity process reviewed to look at ensuring that any patient who has experienced pregnancy loss beyond 13 weeks is automatically offered a follow-up appointment
- new waiting room nurse role introduced in the emergency department (ED) to monitor patients in waiting room for any deterioration and assist patients if needed
- Red Cross volunteers utilised in ED during times of significant pressure to help provide food and drink to patients waiting in the department
- additional training for staff in how to deliver bad news
- local policy changed to be in line with National Institute for Health and Care Excellence (NICE) guidance for scanning for head injuries when a patient is on blood thinners
- Standard operating procedure (SOP) for discharge waiting area (DWA) developed. A nursing assistant is now based in the department to assist with turning patients, providing personal care and making sure patients are offered food and drinks

- developing an alert on medical records that highlights if a patient does not want certain relatives or callers to be aware of their admission
- additional training and education given to ward staff on prevention of patient falls
- oncology will now liaise with a surgeon to review patient scans and whether surgery is an option
- best practice to undertake a bladder scan when assessing possible cauda equina syndrome shared with orthopaedic team
- some staff have undergone additional communication skills training.

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

Managing compliments

A total of 599 compliments have been formally received by WSFT. This figure only includes thank you correspondence shared with, or sent directly, to the patient experience team.

National CQC patient surveys

The Care Quality Commission (CQC) carries out a variety of patient surveys, the most frequent of which occurs annually. Feedback from national as well as local surveys is used to monitor service performance and focus on quality improvement. WSFT was involved in the following CQC surveys which have been reported on during 2023-24:

- 2022 Urgent and Emergency Care Survey (published July 2023)
- 2022 Adult Inpatient Survey (published September 2023)
- 2023 Maternity Survey (published January 2024).

Interpreting our data

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

2022 Urgent and Emergency Care Survey (published July 2023)

Respondents and response rate

- 251 WSFT patients responded to the survey
- the response rate was 28.77%.

Scoring

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

Banding

Much better than most trusts on 0 questions

Better than most trusts on 3 questions

- Q9. Were you informed how long you would have to wait to be examined?
- Q10. Were you kept updated on how long your wait would be?
- Q37. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

Somewhat better than most trusts on 2 questions

- Q31. In your opinion, how clean was the A&E department?
- Q41. Did staff give you enough information to help you care for your condition at home?

Worse than most trusts on 0 questions

About the same as other trusts on 32 questions

2022 Adult Inpatient Survey (published September 2023)

Respondents and response rate

- 509 WSFT patients responded to the survey
- The response rate was 43.69%.

Banding

Much better than most trusts on 0 questions

Better than most trusts on 1 question

- Q12. How would you rate the hospital food?

Somewhat better than most trusts on 0 questions

Worse than most trusts on 0 questions

About the same as other trusts on 44 questions

2023 Maternity Survey (published January 2024)

Respondents and response rate

- 133 WSFT patients responded to the survey
- the response rate was 45.86%.

Banding

Much better than most trusts on 0 questions

Better than most trusts on 8 questions

- C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?
- D2. On the day you left hospital, was your discharge delayed for any reason?
- D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
- D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
- D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?
- D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?
- F2. If you contacted a midwifery or health visiting team, were you given the help you needed?
- F12. Were you given information about any changes you might experience to your mental health after having your baby?

Somewhat better than most trusts on 6 questions

- B10. During your antenatal check-ups, did your midwives ask you about your mental health?
- C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?
- C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?
- D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?
- F5. Would you have liked to have seen or spoken to a midwife. . . (Care at home after the birth)
- F14. Were you given information about your own physical recovery after the birth?

Worse than most trusts on 0 questions

About the same as other trusts on 40 questions

Action plans

Results are reviewed within relevant groups and reported to the experience of care and engagement committee. Action plans are established with the support of the patient engagement team alongside any existing work within the workstreams. Actions from the CQC survey results have included:

- the creation of focus groups in particular areas
- local surveys to determine whether situations have improved
- submission of business cases for more staff resource
- creation of new volunteer roles
- installation of radios and televisions in waiting areas.

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

Health inequalities

Under the First for the Future ambition, the Trust strategy makes a commitment to 'Make the biggest possible contribution to preventing ill-health, increasing wellbeing and reducing health inequalities'. The Board adopted the health inequalities and personalised care strategy in December 2023. The Trust invests in an in-house public health service which provides leadership, specialist expertise and health improvement services across prevention, health inequalities, personalised care and population health management.

The Trust has analysed information on health inequalities in line with NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities. Our analysis to date has three components:

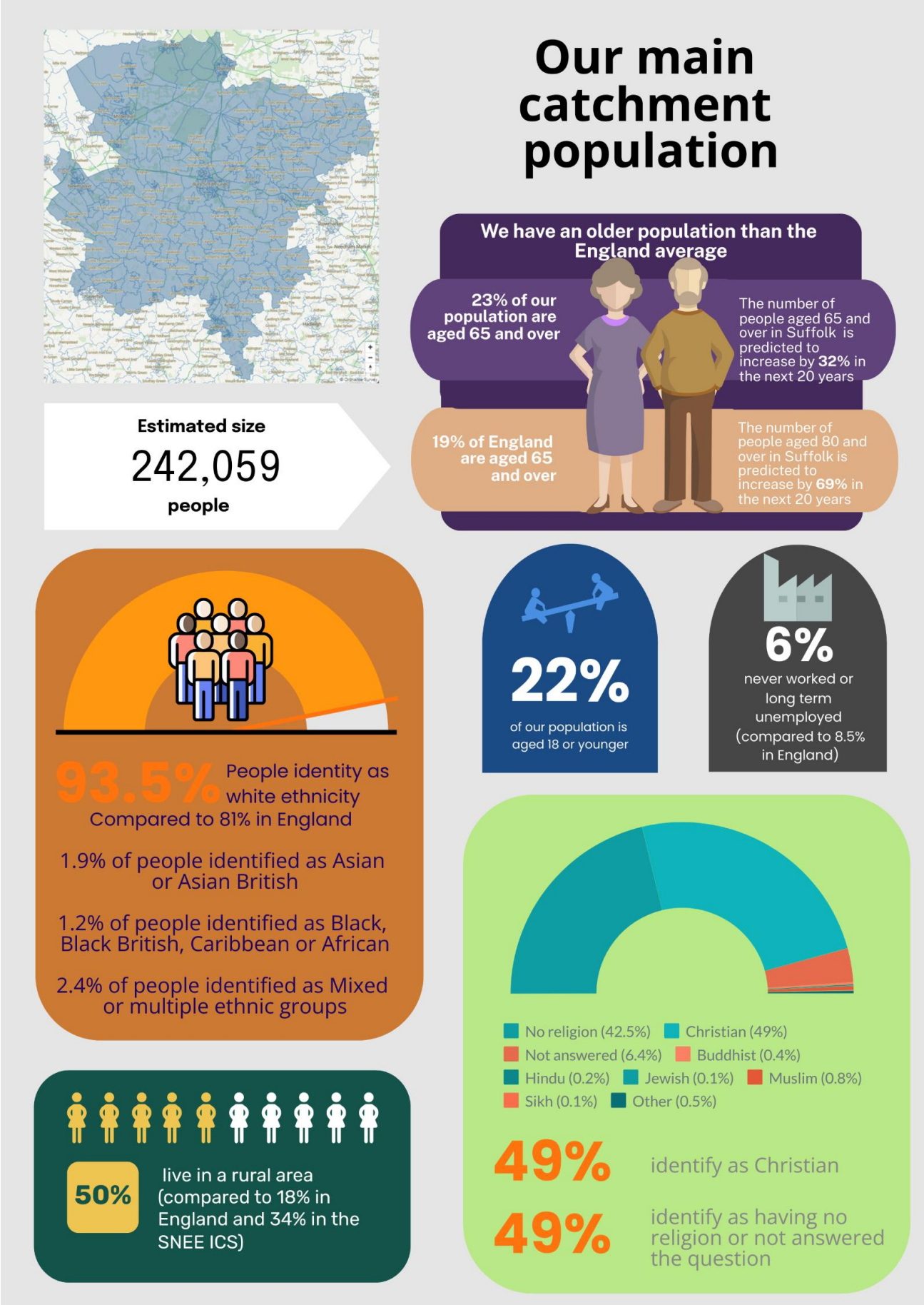
1. Creating a population profile which provides key insights into the characteristics of the population that we serve
2. Assessing the presence of healthcare inequalities for the population groups and services prioritised in NHS England's Core20PLUS5 framework
3. Analysing the indicators in NHS England's Statement on Information on Health Inequalities which are relevant to the trust.

Trust's population profile (2024)

Defining the catchment population of the Trust is difficult. There are no hard boundaries, and we care for anyone who is referred to us or who attends our emergency department. For hospital services, we can look at areas where more than 50% of the population are admitted to us rather than went to be cared for elsewhere. For community services, it is even harder, as we work with several other organisations and look after people over a much wider geography than use our hospital services.

For our first population profile, presented in Figure 1, we have used the national definition of our main hospital catchment area, which also covers the majority of people who use our adult community services and a portion of the people who use our children and young people's community services. Over the course of the coming year, we will develop this in response to feedback from patient and staff and we will extend it to fully describe the population which uses our community services.

Figure 1: WSFT population profile



Infographic generated using Piktochart.com
Source: Office for National Statistics licensed under the Open Government Licence v.3.0
Contains OS data © Crown copyright and database right [2024]

Our main catchment is from west Suffolk and parts of south Norfolk and east Cambridgeshire.

The 2021 Census can give us an idea of the population that lives within these boundaries. We have a generally older population than the England average; 23% of our population is aged 65 and over. The equivalent figure for England is 19%. This increases the likelihood that someone will be living with at least one long term condition. For people aged over 65, our catchment proportion is 20% higher than the England average, suggesting that our population is likely to have higher needs for our services than the national average.

Specific population projections are not available for our population, but the Office for National Statistics produces population projections for Suffolk. This shows that the number of people aged 65 and over is predicted to increase by 32% in the next 20 years. The number of people aged 80 and above is predicted to increase by 69%. This suggests that the number of people living with long term conditions are likely to increase significantly, if we do not do more to stay healthier for longer.

The proportion of people identifying as being of White ethnicity in the Census is significantly higher for our catchment when compared to England (93.5% vs 81%). 1.9% identified as Asian, Asian British or Asian Welsh; 1.2% identified as Black, Black British, Black Welsh, Caribbean or African; 2.4% as mixed or multiple ethnic groups; and 1.1% as other ethnic group. It is important that our electronic patient records accurately record our patients' identified ethnicity as the risk of some diseases is increased for some ethnicities. For example, a UK study showed that people identifying as South Asian or African Caribbean were twice as likely to have diabetes at age 70 when compared to Europeans.

People in our catchment were more likely to have identified as having no religion (42.5%) or Christian (49%) when compared to England. 0.4% were Buddhist, 0.2% Hindu, 0.1% Jewish, 0.8% Muslim, 0.1% Sikh and 0.5% other religion.

When compared to the England average, our catchment is more likely to be in employment.

Half of the people in our main catchment population are classified as living in a rural area. This compares with an average of 18% living in rural areas across the country and 34% across SNEE ICS. Accessing health services can be particularly difficult for people in rural communities.

Core20PLUS5 priority groups and services

The Core20PLUS5 programme is a well-established NHS England programme to reduce healthcare inequalities in adults and children and young people. It prioritises population groups and healthcare services under three headings:

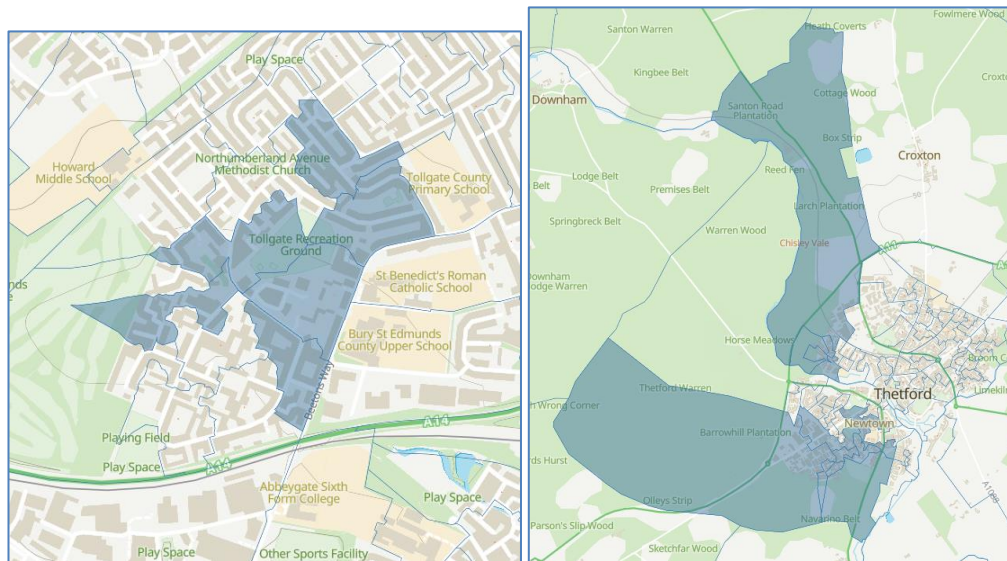
1. Core20 areas – the local areas which, when ranked nationally, are the most disadvantaged 20% in the country
2. PLUS populations – ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone
3. Five clinical priority areas plus smoking – clinical topics where significant inequalities are already known to exist or which contribute most to the overall inequality in life expectancy. Clinical priority areas are defined for both adults and children and young people. Smoking is added to the framework for adults as a cross-cutting topic because it contributes to all five clinical priority areas.

In 2023-24, we have conducted analysis for the Core20 areas, the PLUS populations, and the adult clinical priority areas. Actions have been taken to start to address the health inequalities that have been found across a number of topics. The results of the analysis and the actions taken are described in this chapter of the report.

Core20 areas

There are four Core20 areas in the Trust's main catchment area, where 6,900 people live. One is in Bury St. Edmunds, part of the Howard Estate, and three are in Thetford, which lies within the Norfolk County Council boundary (figure 2).

Figure 2: Maps showing the location of Core20 areas in the main WSFT catchment area (Bury St Edmunds left, Thetford right)



© Ordnance Survey from ONS Census 21 interactive mapping

Source: Office for National Statistics licensed under the Open Government Licence v.3.0

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Understanding these communities is important to reducing healthcare inequalities.

People living in our Core20 areas:

- have higher levels of long-term conditions
- have higher mortality rates
- have worse management of hypertension
- are less likely to be diagnosed at an early stage of cancer.

They also often have higher usage of health services. For example, in 2022-23 the Core20 population in Bury had 25% higher GP consultation rate and 52% higher attendance rate at the WSH ED, compared to West Suffolk as a whole (analysis conducted in the SNEE ICS Optum/Axym population health management platform).

The Thetford communities are likely to be affected further due to their geographic distance from major services.

The highlights from Census 21 for the population of our Core20 areas are:

- they are a significantly younger population. This means their maternity and children and young people, service needs will be higher than our average
- they are less likely to hold a UK passport than the England average, their language skills are good and 96.4% have lived in the UK for at least five years. So, whilst they are less likely to be UK born, they are likely to be able to navigate our systems. However, it should be noted that 3.6% cannot speak English well and 0.5% cannot speak English, so communications need to be carefully considered for these communities
- our Core20 population are of white ethnicity and half are of no religion
- they are likely to have poorer health and more likely to be identified as having a disability
- attending routine appointments may be more difficult for these groups due to the combination of being likely to be in fulltime employment, and the types of occupations they undertake (more routine and manual)

- they largely live in social housing. It is possible that many of this community are not eligible for free prescriptions, so identifying and managing long term conditions or risk factors may add to their challenges.

Action taken in 2023-24

Members of the public health team have worked with West Suffolk Alliance partners to conduct asset-based community engagement with the residents of the Howard Estate in Bury St Edmunds. The team was supported by the West Suffolk Council families and communities officer to make sure that the engagement was culturally competent and didn't repeat questions that had been asked before. The unmet needs revealed included:

- Care closer to the community
 - more services at the community centre e.g. blood pressure checks
 - local blood tests
 - improved access to dentistry
 - minor injuries unit/ eye screening
 - GP presence on the estate.
- Children and young people
 - more activities for young people
 - more funding/support for special educational needs students in schools
 - improved access to mental health (for children and parents).

West Suffolk Alliance partners have already taken action as a result of the engagement. For example, Abbeycroft Leisure has restarted its Teen Chill group for young people at Bury St Edmunds Leisure Centre, which is close to the estate; and the Bury St Edmunds primary care network is proactively identifying people with uncontrolled hypertension in order to improve their control. The improvements in services for the Howard Estate will continue and diversify in 2024-25. The learning will also be extended to other disadvantaged communities in West Suffolk beyond the Core20.

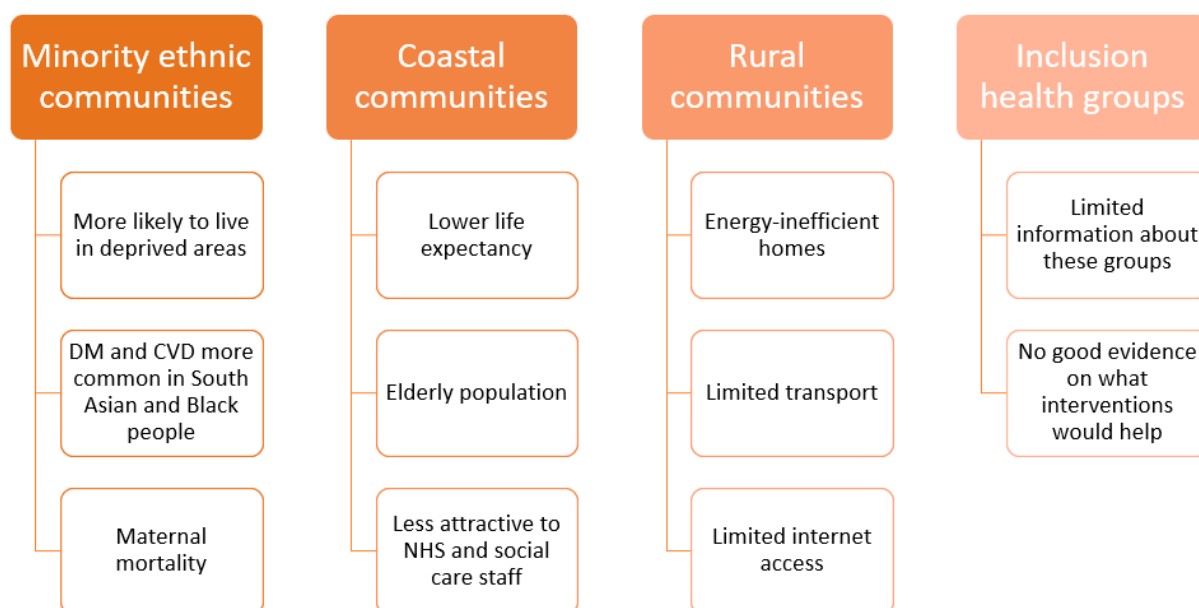
PLUS populations

The PLUS populations for Suffolk were defined in the Suffolk Annual Public Health Report 2022. They are:

- people in minority ethnic groups
- coastal communities
- rural communities
- people and groups facing the sharpest health inequalities in Suffolk (such as groups at risk of disadvantage). This group includes migrants, travellers, people who are homeless, people who are in prison, and sex workers.

The key challenges that the Annual Public Health Report highlights for each of these groups are shown in figure 3.

Figure 3: Characteristics that make the PLUS groups more susceptible to inequalities (courtesy of Maisie Fitzgerald, University of Cambridge)



In 2023-24, we have focussed our analysis on people in minority ethnic groups, people in rural communities, and people who are homeless.

People who are in minority ethnic groups

The COVID-19 pandemic highlighted the significant health inequalities experienced by people in minority ethnic groups, and between different minority ethnic groups. The learning from the pandemic was that it is right and necessary to identify those disparities and to tailor care in response. The foundation of successfully tackling ethnic inequalities in health is recording accurate and comprehensive ethnicity data.

An analysis of eCare information shows 75.3% of people with their ethnicity recorded. The Nuffield Trust undertook a structured review of the quality of ethnicity recording in 2021 that found the national averages for inpatient and outpatient records are 87% and 83% respectively. Under-recording affects different groups differentially. This suggests there are systematic biases in ethnicity recording, which could lead to a bias when assessing access to services, outcomes, complaint rates or when planning services.

Action taken in 2023-24

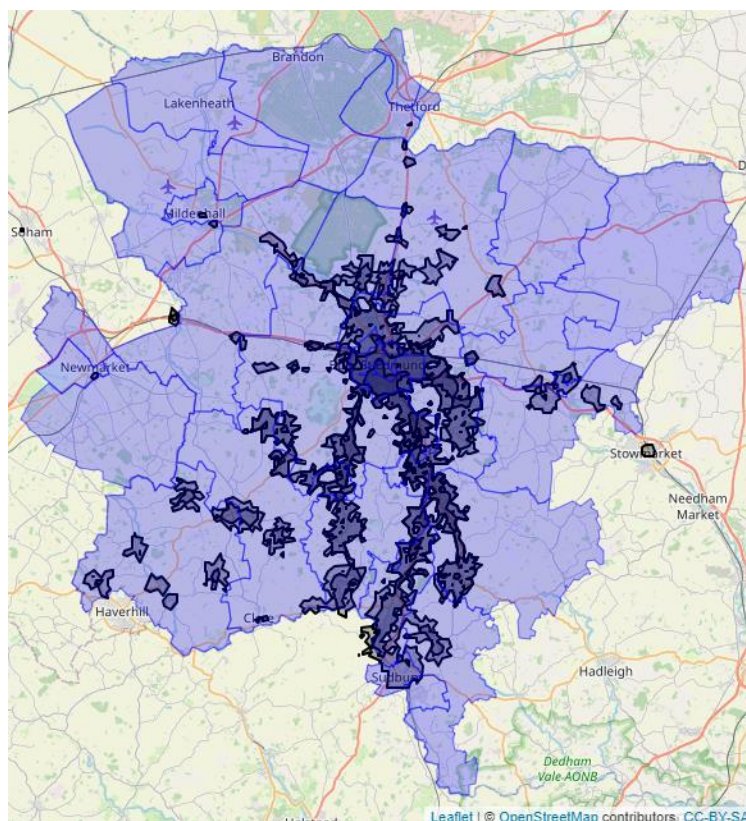
The Board adopted a goal in the prevention, health inequalities and personalised care strategy in December 2023 to increase the accuracy of ethnicity data by 50% by March 2025. An evidence review is being performed to understand the most effective ways to capture accurate data.

Rural communities

Of the people living in our main catchment area, one in two live in a rural area, compared to one in three in SNEE ICS as a whole and one in every five and a half in England.

The key issue for people in rural areas is access to services, including transport options. 14% of households in our catchment area do not have a car or van in the household and another 41% only have one. The availability of private transport affects the ease with which people can get to health appointments and the amount of time a health visit takes out of their day. Public transport options are poor. For example, only one third of people in our main catchment area can travel to the West Suffolk Hospital in less than an hour (figure 4).

Figure 4: Map showing travel duration by walking and public transport to the West Suffolk Hospital site (less than 1 hour dark purple, more than 1 hour light purple)



Source: Office for National Statistics licensed under the Open Government Licence v.3.0
Contains OS data © Crown copyright and database right [2024]

As a crude summary, the rural population is less deprived on average, but older. The prevalence of long-term conditions and mental health diagnoses is similar between both populations. However, if you are disadvantaged in a rural area, your disadvantage is compounded by difficult access to services.

Action taken in 2023-24

Given our geography, all efforts to move care closer to home will help address the access inequalities faced by rural communities. Our community services are already provided in a wide range of community health centres, GP surgeries, schools and other local settings. The expansion of the virtual ward from 30 beds to 60 beds has doubled the number of people who can receive inpatient care in their own home, reducing travel for relatives visiting. The hospital specialties conduct 12.5% of in-person clinic appointments in local settings; in 2024-25 the goal is to increase this figure to 25%, and also to increase the proportion of telephone and video appointments from 22% to 25%.

The West Suffolk Alliance partners have devised a project for 2024-25 to work with Suffolk County Council and community transport schemes to improve access to health services by bus.

The Trust has also assessed the impact of travel times and distances on the movement of services to new healthcare facilities, including the community diagnostic centre at Newmarket Community Hospital, the Essex and Suffolk Elective Orthopaedic Centre in Colchester and the new West Suffolk Hospital.

People who are homeless

Since 2018, emergency departments, urgent treatment centres and hospitals in their function of providing inpatient care have had a statutory duty to refer. A person is considered homeless if:

- they do not have any accommodation which is available for them which they have a legal right to occupy; or

- it is not reasonable for the person to occupy their current accommodation, for example, because they would be at risk of domestic abuse.

A person can also be considered threatened with homelessness if they are likely to be homeless within eight weeks.

In 2022-23, 812 households were assessed by West Suffolk Council as being owed a statutory homelessness duty, 570 of whom were homeless and 242 were threatened with homelessness. (West Suffolk Council residents make up about 75% of the WSFT catchment population). 1.4% of the referrals the council received were from the hospital duty to refer (8 of 832 referrals).

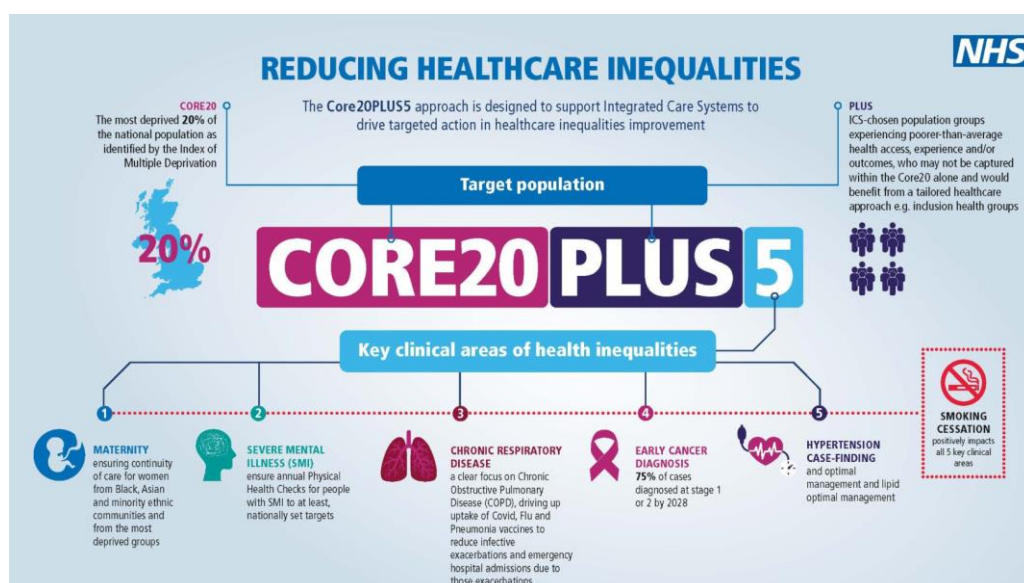
Action taken in 2023-24

A survey was undertaken in the emergency department which showed that awareness of the duty to refer, and the routes to do so, was low, but willingness was high. An awareness raising campaign was run with advice and support from the West Suffolk Council housing options and homelessness team.

Five clinical priority areas for adults

The five clinical priority areas for adults alongside smoking are shown in the Core20PLUS5 graphic in figure 6.

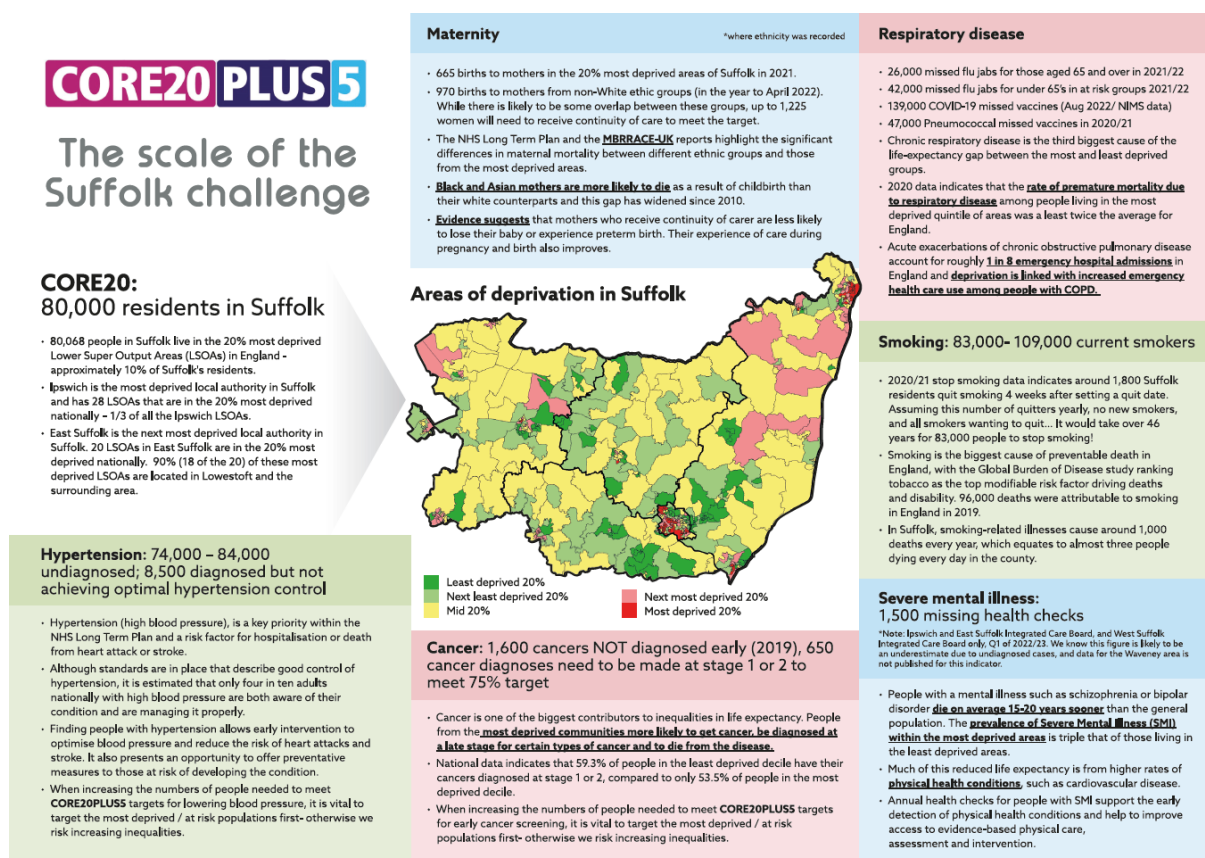
Figure 6: Core20PLUS5 framework for adults



NHS England. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

The Suffolk Annual Public Health Report 2022 has summarised the scale of the challenge against the clinical priority areas for adults (figure 7).

Figure 7: The scale of the Suffolk challenge against the Core20 indicator and the 5 clinical priority areas for adults plus smoking



Healthy Suffolk (2022). Suffolk APHR 2022. Annual Public Health Report (APHR) on Core20PLUS5

In most cases the five clinical priority areas require coordinated action across several organisations to address them; only the maternity priority is uniquely controlled by the Trust. Initial analysis has been conducted to get a sense of the availability of data and the scope for improvement.

Maternity

The priority is to ensure continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.

Nationally available data shows the percentage of all people receiving continuity of care and does not break it down by ethnicity.

Continuity of care requires appropriate staffing levels to be implemented safely. Due to national and local staffing shortages, progress towards the national ambition to provide continuity of care to all people in a Black, Asian and minority ethnicity group has been slow.

WSFT was delivering more continuity of care than the England average up until May 2022 (23% of women) but since then this has been much lower; 6% at the last data collection in December 2023. Census 21 would suggest around 15% of births could be in Black, Asian and minority ethnic groups.

Severe mental illness

The priority is to ensure annual health checks for 60% of those living with severe mental illness (SMI) (bringing SMI in line with the success seen for people with learning disabilities).

The West Suffolk Alliance population does well against this metric. There is evidence of general improvement since a dip in Q4 2020-21. Since Q3 2021-22 we have been close to the 60% target and in the last available quarter (Q4 2022-23) we exceeded the target.

However, the west of Suffolk area appears to have the least complete register of people with severe and enduring mental illness when compared to what is expected from general practice Quality and Outcomes Framework (QOF) registers, with only 62.6% of the expected numbers.

Chronic respiratory disease

This priority has a clear focus on chronic obstructive pulmonary disease (COPD), by increasing uptake of COVID, flu and pneumonia vaccines amongst people who have COPD to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

The available national evidence is that West Suffolk Alliance ranks well for seasonal flu in those aged 65 and over and in the mid-range for pneumococcal vaccine uptake.

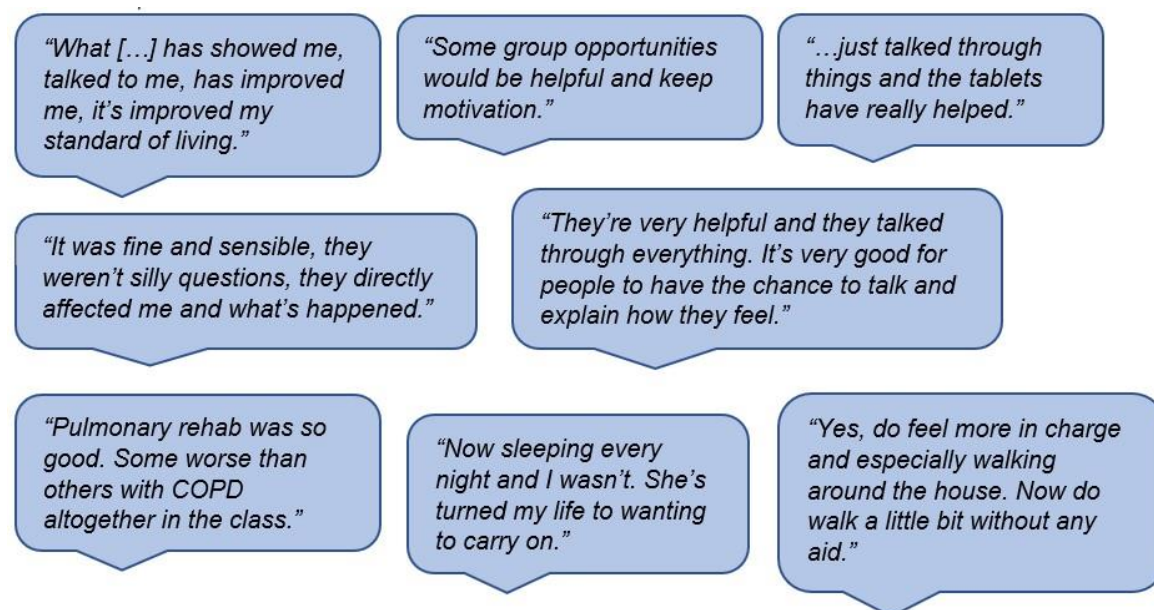
We are aware of healthcare inequalities between our Norfolk and Suffolk patients with chronic respiratory disease and therefore need to work hard to prioritise this group and close the healthcare gap that exists between the counties.

Action taken in 2023-24

In 2023-24, WSFT led two novel pilots targeting people with chronic respiratory disease.

1. More than 800 text messages were sent to people with a respiratory condition diagnosis encouraging uptake of seasonal vaccinations
2. Working with Norfolk partners and the Breckland Alliance, population health management methods and personalised care interventions were used to target people living in Thetford with a diagnosis of chronic obstructive pulmonary disease (COPD). The pilot evaluated well with both the people who participated and the staff who were involved. Examples of patients' feedback on the personalised interventions they received are shown in figure 8.

Figure 8: Quotes from people who participated in the Breckland COPD risk stratification project



We will build on the lessons learned from delivering interventions for people with respiratory disease in the future.

Early cancer diagnosis

In West Suffolk, the proportion of cancers diagnosed at an early stage is consistently above the England average. However, there is no evidence of improvement over the last decade, in West Suffolk or in England. It is likely that the COVID-19 pandemic will have caused a deterioration. Given the trajectory, the pandemic effect and the latest data (57.6%), it looks highly unlikely that we will reach the 2028 target of 75% of cases diagnosed at stage 1 or 2 unless we do something radically different.

As may be expected, there is a consistent healthcare inequality in the stage of diagnosis, with a 7% absolute difference in early diagnosis between the most disadvantaged and least disadvantaged areas.

To make a real impact on the stage of diagnosis for our most deprived communities, West Suffolk Alliance partners would be most successful if our collective efforts were prioritised, guided by six components:

1. incidence of the cancer site
2. impact of early diagnosis on outcomes
3. proportion of cases diagnosed in Stage 1 or 2
4. inequality observed in early diagnosis
5. evidence base for plausible interventions to enhance early diagnosis
6. extent to which these plausible interventions have been fully deployed and/or any inequalities that can be identified in their deployment.

The top three cancer sites for women are breast, lung and bowel; the top three cancer sites for men are prostate, lung and bowel. The data in the table below are for England as a whole.

	Breast	Prostate	Lung	Bowel
Impact of early diagnosis on outcomes	Stage 1 5-year survival 98.2%, Stage 3 73.2%	1-year survival close to 100% until stage 4 89.6%	Stage 1 5-year survival 60.9%, stage 2 38.7%, stage 3 14.7%	Stage 1 5-year survival 92.2%, stage 2 84.6%, stage 3 65.5%
The proportion of cases diagnosed at stage 1 or 2	39.6% diagnosed at stage 1, 38.1 at stage 2	31.6% diagnosed at stage 1, 15.9% stage 2, 18.5% stage 4	18.2% diagnosed at stage 1, 7.4% stage 2, 19.4% stage 3	16.3% diagnosed at stage 1, 22.7% stage 2, 27.1% stage 3
Inequality in early diagnosis	36.5% stage 1 in most deprived quintile, 41.4% in least deprived	33.6% stage 1 in most deprived quintile, 36.3% in least deprived	21.7% stage 1 in most deprived quintile, 22.2% in least deprived	15.1% stage 1 in most deprived quintile, 16.5% in least deprived
The evidence base for plausible interventions to enhance early diagnosis	Strong evidence base for the screening programme	Mixed evidence base for population prostate screening	Developing evidence for lung cancer screening. Successful pilot of 200,000 invites in England	Strong evidence base for the screening programme
The extent to which these plausible interventions have been fully deployed / inequalities in deployment	28% of diagnoses come from the screening programme in the most deprived quintile, 34.1% in the least deprived	Not applicable	Targeted deployment planned across England	8% of diagnoses come from the screening programme in the most deprived quintile, 10.2% in the least deprived

Action taken in 2023-24

In 2023-24, respiratory services at the Trust have successfully undertaken planning and recruitment to introduce the NHS lung health check programme, a national, targeted programme with people aged between 55 and 74 who have ever smoked.

Throughout 2024-25, the Trust will work closely with its system colleagues to implement the programme with a focus on identifying those most at risk, including people from our deprived communities.

Hypertension case-finding

This priority is to encourage interventions to optimise blood pressure and minimise the risk of heart attack and stroke. In terms of identifying people with high blood pressure, West Suffolk compares well nationally although the deprivation gradient is steeper than seen nationally.

The effective management of hypertension continues to improve following the pandemic and in March 2023, West Suffolk was above the England average:

- 70.2% of patients with GP-recorded hypertension had a blood pressure below the age-appropriate treatment threshold.

There was a 6% difference in the effectiveness of hypertension management between those in the most deprived communities and the least deprived (66.3% vs 72.2%). This was similar to the level of inequality seen across SNEE ICS and England.

Cholesterol management had improved slowly and remained above the England average. There was an inequality, with fewer people of black ethnicity being treated with lipid lowering therapy. However, the confidence intervals are wide as only 35 people in black ethnic groups have been recorded as having cardiovascular disease in West Suffolk.

Action taken in 2023-24

Staff in the community services and the public health team have worked closely with GPs and the West Suffolk Alliance to encourage more people to know whether they have high blood pressure.

We ran a pilot scheme, using population health intelligence to identify people with unmanaged and/or unknown hypertension with some surgeries in the Forest Heath and Bury St Edmunds primary care networks:

- we audited primary care records in one practice for patients who had been identified as having high blood pressure by the Trust, and found 30 people whose hypertension was not known to their practice
- in another set of practices, we identified people who had not responded to blood pressure review requests. The primary care network used this list to phone patients and encourage them to measure their blood pressure.

The level of 'yield' from these experiments is being used to inform further action on high blood pressure as part of our board strategic priorities in 2024-25.

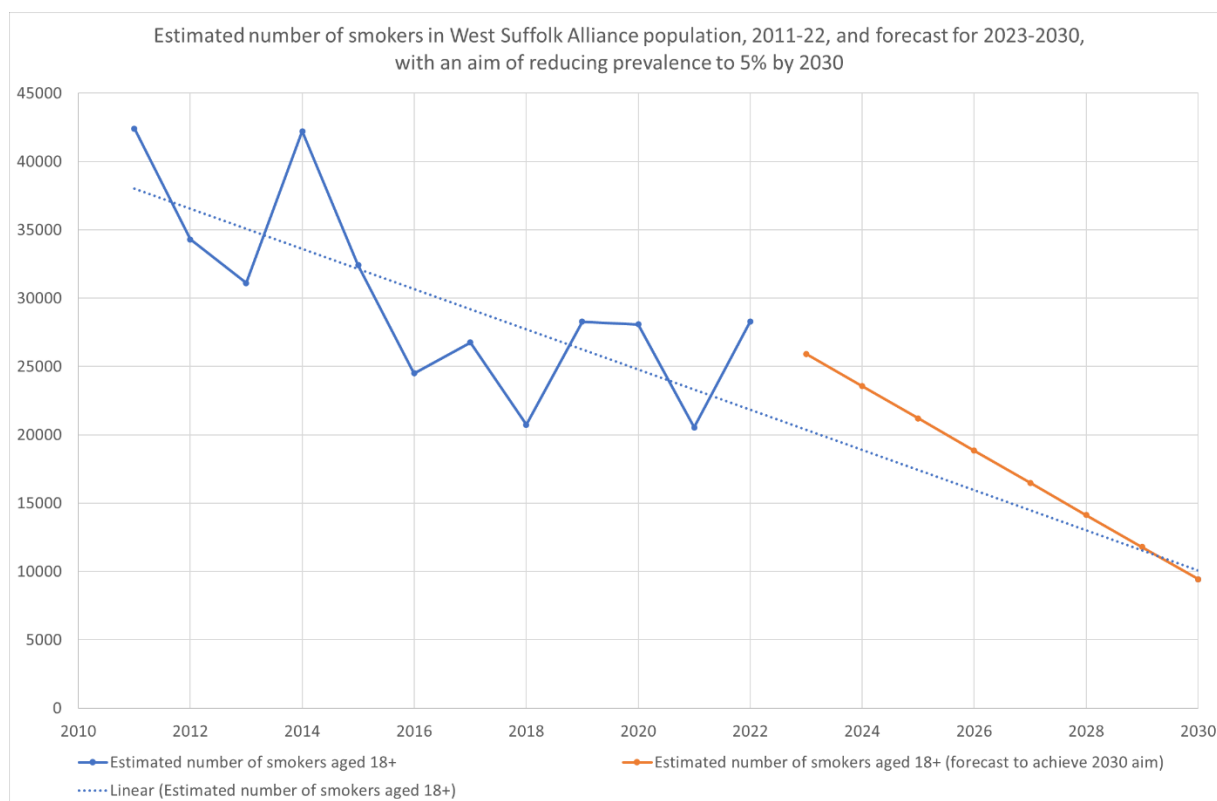
Smoking cessation

Smoking remains the single biggest cause of preventable illness and death in England. Smoking is also the biggest cause of health inequalities. Supporting people to manage their dependence on tobacco and to achieve abstinence from tobacco addiction is therefore a recurrent theme in the health inequalities policy agenda.

The Suffolk Annual Public Health Report 2022 highlights that in Suffolk, smoking-related illnesses cause around 1000 deaths every year, equal to almost 3 people dying every day in the county.

In the West Suffolk Alliance population, there were an estimated 28,267 adults who smoked in 2022. The prevalence of smoking has been on a general downward trend for the last decade, and Suffolk has set a collective aim to achieve a prevalence of 5% by 2030 (figure 9).

Figure 9: Estimated number of adult smokers in West Suffolk Alliance, 2011-2022 and forecast to 2030.



This trend belies the fact that there is a really significant income inequality in smoking prevalence though; people in routine and manual occupations make up over 40% of smokers.

Chapter 2 of the NHS Long Term Plan sets out two goals on smoking cessation which apply to WSFT:

- by 2023-24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
- the model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.

There are also national and local expectations that NHS premises should be smokefree and NHS staff should have access to smoking cessation services.

The one most important thing the Trust can do to reduce healthcare inequalities is to promote smoking cessation at every opportunity. Not addressing tobacco dependence in healthcare settings and contacts is simply exacerbating the healthcare inequalities that people who smoke experience.

Action taken in 2023-24

Acute inpatients

Through collaborative working with SNEE ICB and Suffolk County Council Public Health and Communities team, WSFT established a tobacco dependence team in early 2023. By November 2023, the team was successfully seeing all people admitted to West Suffolk Hospital who smoke, well ahead of the March 2024 deadline. The team uses an opt-out approach, whereby people can decline help at the point that a tobacco dependence adviser visits them to discuss smoking cessation options.

Provisional outcomes for April 2023 to March 2024 include:

- 925 inpatients were offered smoking cessation support
- around half of people opted out of making a quit attempt. Every person who opted out still received very brief advice, harm reduction information and/or support for temporary abstinence for a smokefree stay instead.
- 32% of people were from the 40% most deprived areas
- 33% of people successfully quit and remained smokefree at 4-week follow-up
- 23% of people who lived in the 40% most deprived areas successfully quit.

Maternity

With the benefit of strong partnership commitment, the smokefree maternity pathway was established in May 2023, seeing 100% of pregnant people who smoke and offering support to all their household members who smoke too. Again, this was well ahead of the NHS Long Term Plan deadline of March 2024. The service delivers all the mandated requirements of Element 1: Reducing smoking in pregnancy of the Saving Babies Lives Care Bundle.

The pathway is offered at the pregnancy booking appointment on an opt-out basis. It continues until 6-weeks post-birth.

The first people who have followed the pathway since it started have only just recently given birth, so the quality and outcome measures will become clearer during 2024-25. However, early indications are:

- around 20% of pregnant people who book with the Trust each month smoke (approximately 50 people per month)
- there is a 50/50 split between people who have recently quit, who go onto a surveillance pathway, and people who are currently smoking, who go onto the treatment pathway
- around 60% of smokers make at least one quit attempt during their pregnancy
- smoking at the time of delivery – the principal national outcome measure - has reduced from 11% to close to the national target of <6%.

Feel Good Suffolk

The Trust has supported the development of a new approach to providing community-based healthy behaviours services, being pursued by Suffolk County Council in partnership with the 5 district and borough councils in Suffolk. The new service is delivered under the brand Feel Good Suffolk and covers smoking cessation, adult weight management and physical activity services.

The Trust's public health team has provided specialist advice and consultancy during the planning, design, go-live and post-live development phases. This has included epidemiology, advice on the smoking cessation service model, providing shadowing for Feel Good Suffolk advisors with the tobacco dependence team, and the creation of a quality and clinical governance framework for the partnership.

We will continue to support Feel Good Suffolk in 2024-25, as part of our board strategic objectives, by ensuring a good level of referrals from WSFT services.

Smokefree site

The Trust has built on human factors research and stakeholder engagement, which was conducted during 2022-23, to establish a comprehensive tobacco control plan and a smokefree site implementation plan. The smokefree site working group has included patient representation, staff representation and West Suffolk Council.

In 2024-25, the Trust will be ready to sign the NHS Smokefree Pledge and implement a comprehensive, compassionate approach to achieving a smokefree site at West Suffolk Hospital. We will build on the learning generated during implementation at West Suffolk Hospital to tailor and extend the approach to the Trust's other premises.

Indicators in NHS England’s Statement on Information on Health Inequalities

The final tranche of analysis on health inequalities has looked at the statutory indicators in NHS England’s Statement on Information on Health Inequalities.

As an acute and community Trust, the indicators in the Statement which relate to WSFT are:

- a. elective recovery – elective activity vs pre-pandemic levels for under 18s and over 18s
- b. unplanned emergency care – emergency admissions for under 18s
- c. smoking cessation – the proportion of adult acute inpatient settings and maternity inpatient settings where a smoking cessation service is offered
- d. oral health – inpatient admissions for tooth extractions due to decay in children aged 10 and under.

The Statement requires trusts to publish an analysis of the indicators by age, sex, deprivation and ethnicity. In most cases, we found no evidence of inequalities. The most prominent findings are summarised in the figure 11.

An incidental, but crucial, finding from our analysis is that both ethnicity and postcode are under-recorded in the Trust’s hospital electronic patient record eCare, which impairs the quality of the analysis and creates a risk of inequalities being hidden. The significance of missing data was noted and discussed by the Trust board in December 2023. The analysis presented is therefore subject to that caveat.

The sources of data used for the analysis were the Trust’s hospital episode statistics datasets, the Trust’s population health management database (Cerner HealtheIntent) and the Trust’s tobacco dependence team’s patient database. The elective catchment population is sourced from the Office for Health Improvement & Disparities’ NHS Acute (Hospital) Trust Catchment Populations dashboard.

Elective activity vs pre-pandemic levels

We compared the characteristics of people undergoing elective procedures in 2023 (calendar year) and 2019 (calendar year, defined as pre-pandemic).

Age

- People aged 65 and over are the largest age category receiving elective care. People aged 65 and over make up a quarter of our elective population and half of the people who receive elective care from us.
- There has been no significant change in distribution between the age categories between 2019 and 2023.

Percentage of the population by age	WSFT elective catchment (2020)	People receiving elective procedures, 2019	People receiving elective procedures, 2023
65 and over	26%	52%	51%
19-64	74%	45%	46%
0-18		4%	3%

Sex

- more females than males undergo elective procedures, in line with the sex distribution in our elective catchment population
- there has been no significant change in distribution between the sex categories between 2019 and 2023.

Percentage of the population by sex	WSFT elective catchment (2020)	People receiving elective procedures, 2019	People receiving elective procedures, 2023
Female	52%	54%	52%
Male	48%	46%	48%

Deprivation

- the distribution of deprivation amongst people undergoing elective procedures roughly matches that of the catchment population.
- in 2023, the distribution of deprivation of those having the procedure matched the distribution seen on the waiting list
- 0.80% of patients undergoing elective procedures in 2019 had an unknown postcode. This has increased by over 3 times in 2023.

Percentage of the population by deprivation quintile*	WSFT elective catchment (2020)	People on the waiting list, 2023	People receiving elective procedures, 2023
1	3%	2%	2%
2	17%	15%	16%
3	34%	30%	35%
4	32%	25%	29%
5	14%	14%	15%
Unknown	Nil	14%	3%

* Quintile 1 = most disadvantaged

- analysis of the waiting list data also shows that the most deprived are spending a similar amount of time on the waiting as the least deprived.

Waiting time distribution of people on an WSFT waiting list, by deprivation decile is detailed below from 17 November 2023, WSFT Oracle Cerner HealtheIntent elective recovery dashboard.

Deprivation quintile*	Waiting time quintile*				
	1	2	3	4	5
1	2.5% (174)	2.1% (146)	2.3% (159)	2.5% (172)	2.3% (157)
2	14.1% (967)	14.8% (1013)	15.5% (1064)	14.7% (1008)	15.3 (1047)
3	30% (2060)	29.9% (2053)	30.9% (2121)	30.2% (2072)	29.6 (2030)
4	25.6% (1758)	26.1% (1791)	24.1% (1651)	25.1% (1723)	24.5% (1678)
5	13.9% (950)	14% (963)	13.7% (940)	14% (957)	14% (959)
NA	13.8% (947)	13% (890)	13.4% (920)	13.5% (923)	14.4% (984)

* Quintile 1 = most deprived and shortest wait

Ethnicity

- there has been no significant change in distribution between the ethnicity categories between 2019 and 2023.
- in 2019, 8.6% of ethnicity data was missing. This rose to 11.1% in 2023.

Percentage of the population by ethnicity	People receiving elective procedures, 2019	People receiving elective procedures, 2023
Asian or Asian British	0.36%	0.42%
Black or Black British	0.21%	0.30%
Mixed ethnicity	0.26%	0.33%
Other ethnic groups	0.87%	0.74%
White	89.71%	87.14%
Not stated	8.31%	10.79%
Not known	0.28%	0.29%

Emergency admissions for under 18s

The total number of emergency admissions of patients under 18 years of age reduced by 12.6%, from 6671 in 2019 to 5878 in 2023.

Age

- children aged 0-4 years make up the majority of paediatric emergency admissions
- there has been no significant change in distribution between the age categories between 2019 and 2023.

Percentage of the 0-18 population by age	WSFT emergency catchment (2020)	Paediatric emergency admissions, 2019	Paediatric emergency admissions, 2023
10-17	44%	15%	15%
5-9	29%	10%	12%
0-4	26%	75%	73%

Sex

- more males than females are admitted to hospital in an emergency, in line with the sex distribution in our emergency catchment population.
- there has been no significant change in distribution between the sex categories between 2019 and 2023.

Percentage of the 0-18 population by sex	WSFT emergency catchment (2020)	Paediatric emergency admissions, 2019	Paediatric emergency admissions, 2023
Female	49%	47%	48%
Male	51%	53%	52%

Deprivation

- the distribution of deprivation amongst children and young people admitted to hospital in an emergency roughly matches that of the catchment population
- the percentage of paediatric admissions with missing deprivation data has increased fivefold between 2019 and 2023
- there has been no significant change in distribution between the deprivation categories between 2019 and 2023, where data is known.

Percentage of the population by deprivation quintile*	WSFT elective catchment (2020)	Paediatric emergency admissions, 2019	Paediatric emergency admissions, 2023
1	3%	4%	2%
2	17%	19%	18%
3	34%	32%	30%
4	32%	26%	24%
5	14%	16%	13%
Unknown	Nil	2%	10%

* Quintile 1 = most disadvantaged

Ethnicity

- there has been no significant change in distribution between the ethnicity categories between 2019 and 2023.
- notably, the paediatric service captures ethnicity data with much higher completeness than average. In 2019, 1.9% of ethnicity data was missing. It rose to 3.5% in 2023, but nevertheless is much lower than for the adult dataset. This suggests an area of good practice in the paediatric service which could be learned from.

Percentage of the population by ethnicity	Paediatric emergency admissions, 2019	Paediatric emergency admissions, 2023
Asian or Asian British	1.65%	2.59%
Black or Black British	0.49%	1.16%
Mixed ethnicity	3.90%	0.91%
Other ethnic groups	1.59%	1.31%
White	90.47%	87.82%
Not stated	1.63%	3.13%
Not known	0.27%	0.37%

The proportion of adult acute inpatient settings and maternity inpatient settings where a smoking cessation service is offered

As described in section 8.2.4, the Trust offers a smoking cessation service in all its adult acute inpatient wards and in the maternity inpatient setting at West Suffolk Hospital.

In 2024-25, the smoking cessation service will be extended to cover both the adult community inpatient ward at Newmarket Community Hospital and the virtual ward.

As additional analysis, we have looked for inequalities in the uptake of nicotine replacement therapy and the 4-week quit rates amongst different groups.

Age

- there was no significant difference in uptake of NRT between people aged 65 and older and people aged 18-64 years.
- people aged 18-64 were 50% more likely to quit following support from the service than people aged 65 and over.

Percentage of service users by age	Accepted NRT	Successfully quit at 4 weeks
65 and over	59%	14%
18-64	57%	22%

Sex

- females were more likely to accept the offer of NRT but were less likely to have a successful 4-week quit.

Percentage of service users by sex	Accepted NRT	Successfully quit at 4 weeks
Female	63%	44%
Male	55%	56%

Deprivation

- there is no deprivation gradient in the uptake of NRT or in quit status at 4 weeks.

Percentage of service users by deprivation quintile*	Accepted NRT	Successfully quit at 4 weeks
1	60%	21%
2	58%	12%
3	56%	17%
4	58%	22%
5	65%	15%

* Quintile 1 = most disadvantaged

Ethnicity

- the small numbers of service users in minority ethnic groups mean the data mean we are unable to comment on outcomes by ethnicity category
- to check for a trend of people in minority ethnic groups receiving a worse quality service than people in White ethnic groups, outcomes have been analysed for people in all minority ethnic groups compared to people from any White background
- there is no indication of lower uptake of NRT in people in minority ethnic groups
- there is an indication of lower quit success at 4 weeks amongst people in minority ethnic groups. The numbers are small (the total number of service users in minority ethnic groups was 20) but this signal will be investigated further.

Percentage of service users by ethnicity	Accepted NRT	Successfully quit at 4 weeks
White	58%	17%
All other ethnicities	60%	5%
Not stated	63%	19%

Inpatient admissions for tooth extractions due to decay in children aged 10 and under

The limited number of extractions performed in 2019 and 2023 (60 and 62 respectively) means we are unable to comment on the distribution of patients according to age, sex, deprivation, or ethnicity.

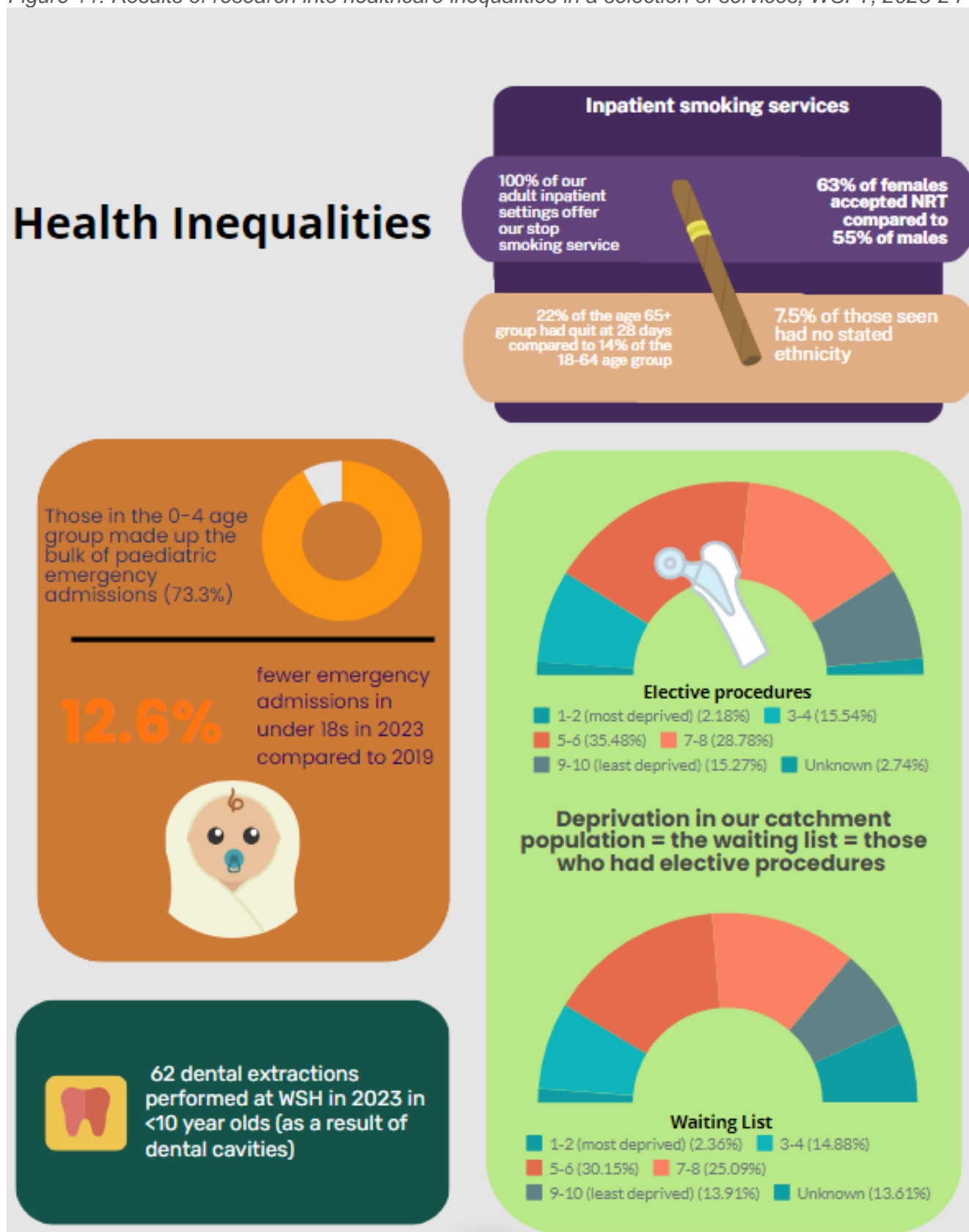
Actions which will be taken in response to the findings of this research

Throughout 2024-25 we will:

- increase the accuracy of ethnicity recording by 50% by March 2025
- investigate the reasons for missing postcode data (which informs deprivation status) and improve its collection
- analyse waiting list data by specialty, to see if there are inequalities in access to individual services
- continue to monitor the smoking cessation service's outcomes for people in minority ethnic groups

- review the literature on differential uptake of smoking cessation services by age, sex and ethnicity. Implement any evidence-based interventions which are identified.

Figure 11: Results of research into healthcare inequalities in a selection of services, WSFT, 2023-24



Infographic generated using Piktochart.com

1.2.4 Principal risks and uncertainties

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

Board assurance framework (BAF)

During 2023-24 the Board refocused its approach to the BAF, reviewing the strategic risks and the Board's risk tolerance for these one. The BAF was regularly reviewed during 2023-24 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting strategic objectives. The BAF illustrates the escalation processes to the Board and its sub-committees when risk, financial and performance issues arise which require corrective action.

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

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

Effective risk and performance management

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

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

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

The Trust actively engages with its foundation trust membership and the public through regular talks, events and communications.

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

Mandatory service risk

The Trust's Board of directors was satisfied that:

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

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

Risk of any other non-compliance with licence

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

Contractors and suppliers

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

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

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

Additional disclosures required by the financial reporting manual (FReM)

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

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

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

Audit committee's review of the annual report and accounts

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

Social, community, anti-bribery and human rights issues

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

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

Over the past year the Trust has reviewed its policies in line with 'Just Culture' principles and has embedded this within policy approval and decision-making frameworks. The Trust has also committed to delivering the actions

within the Unison Anti-Racism Charter and has signed the Inclusive Leadership Pledge as part of its commitment to being an inclusive organisation.

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

Over the past year the LCFS has delivered the following:

- undertaken obligatory tasks specified by NHS Counter Fraud Authority (CFA) to inform the Counter Fraud Functional Standard Return
- delivered (bespoke) fraud awareness training to consultants and nursing and community staff, (the training audience has varied each year to ensure that everyone is covered on a cyclical basis)
- fraud and bribery awareness sessions were delivered by remote training sessions on recruitment and cyber workshops was delivered to the Trust Board
- 'Notice Frauds' sent to the Trust as and when LCFS receives a fraud alert, which is responded to and recorded by LCFS (to report back to NHS CFA). These notices cover mandate and cyber frauds
- completed a specific review, linked with the work completed by the Trust's internal auditors, on Annual Leave Management
- reviewed the Trust's controls around conflicts of interest and gifts and hospitality.

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

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

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

The NHS requires compliance reporting on 67 core standards for which there are grades of achievement; full, partial or non-compliance. Core standards require the 'completion' of all activities to record 'full compliance'.

As a result of self-assessment, the Accountable Emergency Officer (AEO) considered that the Trust overall level of compliance was 'partially compliant' in that there were seven core standards in four capability areas where there was not full compliance:

- training (three standards)
- business continuity management (two standards, down from four last reporting period)
- decision logging (one standard)
- full wet decontamination of self-presenters at the Emergency Department.

There were mitigations in place, and there was confidence that the Trust could operate in the interim until each standard became fully compliant. The Trust has committed to achieving full compliance by the next assessment in September 2024 but, as ever, this is dependent on the changeable operating environment and staff capability.

For context, in 2021 the Trust was non-compliant in five standards and in 2022 the Trust was non-compliant in 10 standards (of which only one standard was the same as 2021); this is a similar trend to other trusts as reporting has become attuned to the delivery of operationally-effective outcomes as a result of the pandemic experience. The Trust can declare overall partial compliance as there are plans to address all the non-compliant areas.

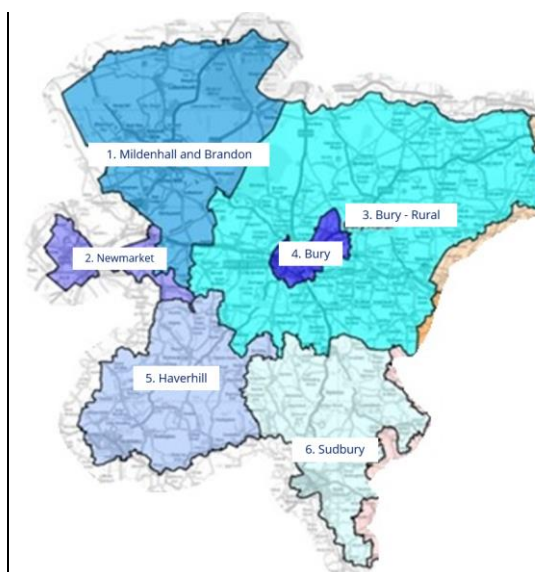
1.2.5 Future business plans

1.2.5.1 Integrated care system (ICS)

West Suffolk Alliance

Purpose

West Suffolk Alliance is one of three place-based alliances across the Suffolk and North East Essex integrated Care System (ICS). The alliance purpose is to 'Improve Health through Partnership' using the 'Live Well' model (below), working in six localities and also joint working themes on premises, workforce, locality working, digital and data.



The Alliance is led in this purpose by a committee of senior West Suffolk leaders. This committee also functions as a part of SNEE ICB Board to commission community health services, primary care and medicines optimisation for West Suffolk. The Alliance is led by the West Suffolk alliance director who is also a member of the WSFT executive team and board. This builds on the long tradition of integration in practice philosophy in West Suffolk.

West Suffolk Alliance Partners

<ul style="list-style-type: none"> • Babergh and Mid Suffolk District Councils • Community Action Suffolk • Healthwatch • Norfolk and Suffolk NHS Foundation Trust • Primary Care Networks • Suffolk County Council • Suffolk and North East Essex Integrated Care Board • West Suffolk District Council • West Suffolk NHS Foundation Trust 	<ul style="list-style-type: none"> • Abbeycroft Leisure • Allied Health Professionals Suffolk • Care UK • Citizens Advice West Suffolk • Home-Start • Local Pharmaceutical Committee • Primary care (24 GP surgeries) • St. Nicholas Hospice • Suffolk Constabulary • Suffolk GP Federation • Suffolk MIND • West Suffolk College
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2023-24 progress

The WSFT Board received regular updates on the progress being made by Alliance partners. Some key areas of progress are as follows:

- diabetes – West Suffolk GP practices have increased the percentage of patients receiving the evidence based eight care processes to be above national average benchmarks.
- dementia – a multi-partner strategy was agreed; NSFT increased monthly dementia diagnosis capacity which is leading to lower waiting times.
- Haverhill – the health centre has reopened following a multi-partner review which supports integrated working and optimum use of space; high level of partnership work
- transport - additional direct bus routes have been agreed from to WSFT from Haverhill and Sudbury (following work with Suffolk County Council)
- community services contract - the Alliance agreed to extend the contract with WSFT for a further three years to April 2027. This decision followed a review of the service which identified excellent progress on integration.
- prescribing – recruitment of liaison pharmacist across WSFT and primary care
- high blood pressure – began working with the community in the Howard Estate in Bury St Edmunds to increase identification of high blood pressure and enable more people with hypertension to control their blood pressure to within manageable limits
- healthy lifestyles – Suffolk County and District Councils launched the Feel Good Suffolk service in October 2023 to support change to healthy behaviours including stopping smoking and reducing weight.

1.2.5.2 Performance improvements and developments

Operational achievements during 2023-24

The NHS 2023-24 priorities and operational planning guidance set out three key tasks: The immediate priority to recover core services and productivity; making progress in delivering the key ambitions in the NHS Long Term Plan and thirdly, to continue transforming the NHS for the future. These aims were detailed into 31 national NHS objectives, the majority of which applied to WSFT across our acute, community and primary care services. Performance and activity trajectories against selected objectives are agreed on an annual basis in conjunction with the Suffolk and North East Essex Integrated Care Board (SNEE ICB).

Continuing to tackle the elective backlog and reducing long waits has been a key priority nationally and for the Trust. We have, for much of the year, maintained a position of zero patients waiting 104 weeks or more and have continued to make progress against the existing priority of eliminating waits of 78 weeks or more, finishing the year with 47 patients waiting longer than this, of which 37 were capacity related and the rest where patients had chosen to wait longer, or treatment within 78 weeks would not have been clinically appropriate, against a forecast of 55 capacity breaches. A new priority for 2023-24 was to go further and eliminate waits of 65 weeks or more, against which we ended the year with 399 patients. Although this was greater than our planned trajectory of 94 patients, almost 15,000 long waiting patients were treated during the year to deliver this, in the context of significant numbers of routine appointments and treatments which were cancelled in response to the multiple rounds of industrial action throughout the year.

In response to our non-zero planning trajectory for reducing but not fully eliminating 78 and 65 week waits, due to known capacity challenges, WSFT benefited from collaboration with system and regional partners as part of 'Tier 2' arrangements. From this we were able to improve on our original plan through additional activity and reviewing the clinical pathway. Transformation programmes have also positively impacted our productivity in outpatients, making progress against delivering 25% of consultations virtually (monthly average of 24.2%) and 5% of attendances to be transferred to patient initiated follow up (monthly average of 3.8%). Rapid progress has also been achieved in increasing theatre utilisation 'touch time' from 68.2% in March 2023 to 76.2% in March 2024.

Performance against the Cancer Waiting Times standards has been focused on reducing the backlog of patients waiting 62 days or more and on making progress towards meeting the faster diagnosis standard of at least 75% of patients receiving a definitive diagnosis or ruling out of cancer within 28 days. We have reduced

the number of patients waiting 62 days or more from 121 to 68 during the year, outperforming the target of 93 patients and contributing to the regional backlog of patients being at its lowest since June 2021. Our faster diagnosis standard performance for March 2024 is 76%, comfortably meeting the performance standard of 75%. Our cancer board, operational and clinical teams have pioneered the transformation of services to deliver this, for example straight to treatment pathways for suspected skin cancer and nurse led triage and straight to test 'one-stop' in gynaecology and head and neck.

In May 2023 we reintroduced reporting against the urgent and emergency care four-hour standard, having not reported this metric since 2019 as a pilot site for the Clinical Review of Standards. Performance started strongly but became challenged as operational pressures increased during autumn and winter. However, we were able to deliver three consecutive months of improvement during quarter 4, finishing March 2024 at 74% against a target of 76%. Our urgent and emergency care services have experienced sustained high levels of demand throughout the year which at times of extreme pressure have increased the length of time patients spend in our emergency department (ED). However, we have been able to make progress in reducing the percentage of patients spending 12 hours or more in the department from 13.4% of attendances in March 2023 to 7.7% in March 2024.

Improvement initiatives delivered in the ED, in our flow of patients through our acute and community beds and into care settings beyond have contributed towards our overall performance delivery and ensure that more patients can receive care in their own homes after a hospital stay. Our community services met and improved performance against the two-hour urgent community response target, once again being consistently above 80% against the 70% threshold.

Work on the RAAC (reinforced autoclaved aerated concrete) programme has progressed well over the last year. Work completed in September on installation of the anodes and application of new external coatings to wall planks which will prevent degradation of these planks. With regards installing the failsafe system, there are just four more wards and a section of corridor to complete. It is anticipated that this work will be completed this financial year (by the end of March). This will ensure that the existing hospital building can continue to be used safely until the move to the new hospital in 2030.

Priorities and operational planning guidance for 2024-25

The overall priority for NHS planning in 2024-25 remains the recovery of core services and productivity, whilst improving patient outcomes and experience through these headline ambitions:

- improving emergency department waiting times
- reducing long waits for elective procedures
- improving performance against the core cancer and diagnostic standards
- improving access to community and primary care services.

These ambitions are detailed within 32 objectives, the majority of which apply to our integrated acute, community and primary care services.

For urgent and emergency care, delivering at least 78% against the four-hour standard and further reducing the number of patients spending 12 hours or more in the ED will need to be achieved through improving flow and length of stay, and continuing to develop services that shift activity from acute hospital settings. To support this, our community teams and social care partners will continue to work collaboratively to make use of intermediate care beds with enhanced wraparound support. This means that people who do not need all the facilities of an acute hospital bed can receive care in a more appropriate setting more quickly, including in their own homes. This will also be supported by the next phase of expansion of our virtual ward from 40 to 100 beds. By facilitating the right care, in the right time at the right place we can ensure that our system partners can deliver care when it is needed and reduce delays in both accessing care and supporting more timely discharge home.

Our primary care services delivered at Glemsford Surgery will build on the progress of last year in contributing to a system-wide increase in appointments and patients being offered an assessment of need, or signposted to an appropriate service, at first contact with the practice through use of high-quality digital and telephony tools. Data from these tools will inform a full understanding of primary care demand and capacity as required by this year's objectives.

Delivering more activity compared to pre-pandemic levels will, as in previous years, be key to further reducing waiting times for elective patients. Activity targets were reduced during 2023-24 in recognition of the impact of industrial action and will return to 108% of 2019-20 for the Suffolk and North-East Essex system. The target to eliminate elective waits of 65 weeks or more (except where patients choose to wait longer or where it would not be clinically appropriate to treat within 65 weeks) has also been extended from March to September 2024, requiring our known capacity challenges to be resolved that have prevented us from delivering a zero position.

To support the delivery of more activity and reducing waiting times, specific objectives building on the progress already made within our operating theatres will need to continue, with at least 85% of suitable procedures being delivered as day cases and 85% theatre utilisation achieved. For the first time we will also be required to achieve an increase in the proportion of outpatient appointments that also have a procedure performed at the same time, meaning more treatment pathways can be completed whilst avoiding further visits to our hospitals.

As a result of the cancer backlog of patients waiting 62 days or more returning to pre-pandemic levels nationally, focus will return to the number of patients achieving the 62-day referral to treatment standard to at least 70% by March 2025. This will be supported through increasing the percentage of patients who must meet the 28-day cancer faster diagnosis standard to 77% at the same time. Building on the progress we have made across our cancer pathways this year will put us in a strong position to achieve this.

For diagnostics, 2024-25 is the second year of a two-year objective to increase the percentage of patients that receive a diagnostic test within six weeks to 95% by March 2025. The opening of our Community Diagnostic Centre at Newmarket Community Hospital, currently planned to be opened by Christmas 2024, will provide significant additional capacity to reduce waiting times, alongside modality specific improvement plans which will continue throughout the year.

Business planning for 2024-25

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

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

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

Joint forward plan and capital resource plan

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

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

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

The JFP continues to provide the structure through which improvement and transformation are delivered to achieve the outcomes of the six domains.

The Trust worked with SNEE ICB to agree the distribution of capacity funding for urgent and emergency care and for discharge capacity, including increased capacity for integrated therapies and the early intervention team, an additional discharge vehicle, and additional rehabilitation beds with wrap around support to reduce length of stay and maximise patient outcomes.

New healthcare facility (Future System programme)

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

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

The Trust, its partners within the local integrated care system (ICS), members of the central new hospitals programme (NHP) team and West Suffolk Alliance, are involved in a comprehensive and inclusive programme of work that will encourage input from a broad set of stakeholders.

Progress to date

Following the development control committee meeting, which was detailed in the 2022-23 annual report, the formal closure of the Section 106 agreement, the range of terms and conditions associated with the outline planning consent, has been agreed and signed off by all parties. This allows the local planning authority to formally issue notice of our outline planning consent.

The programme continues to progress at pace, particularly in relation to enabling works. Enabling works are a part of planning permission requirements and prepare a site for the forthcoming development and, excitingly, these have begun.

The first of many requirements was the moving of approximately one hectare of fungi from its location on Hardwick Manor (the development site) in Bury St Edmunds to two new donor sites, with similar soil characteristics. This is now complete with habitat recreation continuing at the receiver sites.

In terms of our on-site enabling works, the programme has secured a position in the UK Power Networks programme of works which will ensure the necessary power upgrades are completed (on site and within the wider power network) before a new hospital becomes operational.

Archaeological work is underway, progressing well and has yet to make any substantial discoveries which would impact the development of the new hospital. The trenching of the development site has been completed and work on the exploration of our construction compound area has commenced and is due to be completed by the end of 2024.

Planting of buffer trees which will reduce the visual impact to our neighbours has started. The buffer planting has been started at this early stage so that they may become established and effective as soon as possible. The buffer planting will be completed in two phases, the second of which is within the 2024-25 financial year.

Construction is underway of the temporary access road that will allow site traffic to access Hardwick Manor from the area of the education centre before the main access road is built. Once completed, the buffer planting at the end of Sharp Road will begin, this is likely to be at the end of the year due to planting seasons. The completion of the buffer planting at the end of Sharp Road will prevent it being used for vehicular, cycle and pedestrian access and maintain good relations with our neighbours.

To make sure we have the right number of employees in the new hospital we have created a staffing plan. The plan has been developed with expert input from partners across the West Suffolk healthcare system and the Suffolk and North-East Essex Integrated Care Board (SNEE ICB). The plan considers four key factors: anticipated patient needs, data used to predict future healthcare demands, changes to the way care will be delivered and the amount of space needed for different departments and services. This space requirement, known as the 'schedule of accommodation', (the shopping list of departments and room sizes on which our architectural designs are based) guides our architectural design. By aligning both the building design and staffing plan with the same future demand predictions, we are aiming to facilitate a smooth and efficient transition into the new building and associated new ways of working.

The final departmental designs to a scale of 1:200 continue to be refined and converged with the guidance provided by the New Hospital Programme.

The Future System programme digital strategy was launched in 2023 and laid out the foundations of our future technology roadmap which will underpin the new hospital building for our patients, and how we work differently as an organisation. The strategy brings together the 'long list' of technologies required for the programme and forms the basis for our future digital ambitions.

The Future System programme continues to work with those most affected by the new hospital, staff, patients and members of the community. Full details on engagement activity to date can be found in section 16 (c).

Next steps

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

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

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

Trust digital programme

Clinical systems

A continued focus for the digital programme is the replacement of paper-based systems with modern digital technology solutions but only where these offer significant benefits to clinical and operational teams. An excellent example of this is the introduction of a digital tool to support shared decision-making, which ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment and indeed considers the consent for treatment a key element of the care. We are rolling out digital consent forms speciality by specialty to support improved decision making, to provide better information for patients about their procedure and to detail any associated risks. It offers a much more efficient process than the paper-based approach.

Digital technology offers the chance to deliver healthcare in new and innovative ways. To this end we have implemented an improved digital tool to support virtual consultations. From the clinician's point of view, it is fully embedded into the main patient record making it an easy option for those situations that would benefit from not having to see the patient in clinic face to face. For the patient it offers an easy to follow process that does not require any local installation of software and leads them through the steps to connect with clinician on line.

We have implemented an enhanced solution for patients to check in for clinic appointments. The solution provides for much improved patient flow that may be required in the new hospital with patient calling screens to help direct patients to the appropriate waiting area or clinic room. Further features will be rolled out in due course that will allow patients to check in remotely and provide more detailed guidance to their location via their smartphone.

Working closely with the community clinical teams, we have co-designed, developed and deployed a wide range of improvements to the community workflows, particularly in support of the integrated community paediatric service, but also covering other community specialities. This extensive package of enhancement work received positive feedback in enabling the streamlining, standardisation and optimisation of the use of the community electronic patient record.

With their withdrawal from the market, we were successful in replacing the innovative clinical messaging solution, Medic Bleep, with the Alertive platform that is well established in a number of trusts regionally and nationally. This enables much more granular prioritisation of messaging between clinical staff than a simple bleep could provide and can be targeted at a specific type of message to relevant individuals, roles or groups. The next phase will deliver greater integration into the electronic patient record.

Supporting digital technology

In addition to the significant investment in the network infrastructure, we were able to secure additional funding to replace the Wi-Fi network across the acute hospital site. This enables additional management capabilities and supports the latest network protocols. The next phase of the work is to install external access points at the rear of the site to enable continuous Wi-Fi signal when moving between buildings

Towards the end of the year, we have started work on the Windows 11 upgrade which includes new hardware that is required to run the operating system. This work will continue in phases throughout 2024 and through 2025.

Additionally we are replacing our mobile device management software to use the latest Microsoft products to manage not just mobile devices but also Windows computers. This will enable much smoother and more reliable deployment of apps, packages and upgrades.

We are actively planning our next steps in our move to use cloud based services where feasible and financially viable. This is supported by the NHS England Cloud Centre of Excellence and follows national guidance on adopting cloud technologies. This will enable a smaller on site digital footprint in the new hospital.

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

Digital across West Suffolk and the wider community

Some of our digital team colleagues are active members of the West Suffolk Alliance digital change group which aims to coordinate digital activities and align to the alliance strategic direction in support of the Live Well domains objective. There is growing demand for tools to support shared care pathways across the full range of providers involved in an individual's care

We continue to run the Health Information Exchange (HIE) on behalf of SNEE ICS and have seen further uptake in monthly usage to more than 150,000 views per month with connections to all the main providers in health and social care across the ICS. We estimate the patient population to be around 2 million people that are covered by HIE, and more than 9,000 staff use every month.

We now integrate with the NHS app and display any forthcoming hospital appointments. Future development will enable cancellation and re-booking of appointments in due course.

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

Future foundations

Whilst digital can support many initiatives of the green agenda through reducing travel or paper usage, digital is not only part of the solution but is also part of the problem. Additional digital platforms do incur running costs in terms of server and disk space and capacity as well as increased power and cooling consumption. We are looking at ways to quantify the green 'cost' of digital and help to work towards our net zero ambitions.

NHS England introduced a Digital Maturity Assessment that assessed all acute trusts, community providers and ICSs on the dimensions of their published 'What Good Looks Like' framework. The Trust was scored as one of the highest in the region reinforcing our position as a global digital exemplar.

Our strong position on digital is helping to support the plans for the new hospital. The national New Hospital Programme expects a smart hospital of the future to deliver a wider range of innovation digital solutions that supports staff productivity, engages with patients and carers and delivers smart building management. We are well placed to rise to the challenge and have recently completed assessments of our digital competencies and capabilities.

Artificial Intelligence (AI) continues to offer huge productivity benefits at the same time as presenting significant risks around its governance, its reliability and acceptance by us as a society. We will be engaging widely with our communities on developing our approach to AI and have a number of positive outcomes from its use in a number of specialities to date.

Procurement

The procurement landscape is still being impacted by inflation increases, and reduced supply chain routes leading to limited availability of certain products. Our procurement team continues to engage with SNEE and regional clinical networks to align contracts and explore collaboration opportunities where benefits have been identified.

The areas of direction currently under review are:

- ensure implementation of the new Public Contract Regulations in 2024
- implement the new carbon emission requirements for the NHS
- monitor key performance indicators around identified social value metrics
- undertake a review of procurement functions under the new Commercial Continuous Improvement Assessment framework introduced in 2022
- establish pipelines and saving across the ICS by utilising the national procurement system Atamis.

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

- support the directorates to identify and achieve cost improvement targets
- successful implementation of the new inventory management solution funded by NHS England
- align the procurement strategy with the ICS procurement strategy.

Agency rules

The two main clinical staff groups where agency staff are used are doctors and nurses. During 2023-24 we continued to use the agencies on the collaborative procurement partnership (CPP) framework preferred supplier list for nursing staff and medical staff, which was developed with the East of England procurement hub. The CPP framework is audited by the procurement hub for framework compliance.

In 2023-24 our agency usage increased by 12%.

Capital planning

In preparing for the delivery of the Future System Programme (FSP), in the past 12 months we have been developing a capital programme that extends to the remaining life of the current WSH asset (2030). This work continues to ensure we have a plan in-place to support risks specifically around the infrastructure that are anticipated in that timeframe. This builds upon the plan identified in the 2023-2028 estates and facilities strategy and ensures that planned investment in community and acute services are identified.

We will develop the programme to a more detailed level for the next three financial years with a granular level of detail for 2024-25. As in previous years, the programme has been developed by input and review from a multi-professional group using a risk ranking process. This assesses the benefits of investment against four criteria: compliance with the estate strategy; operational/clinical need; financial impact; and statutory compliance.

The assessment ensures that:

- risk priorities remain relevant and have not changed
- any changes are incorporated from statute, alerts, NHS estates, etc.
- any previously unidentified issues arising in the year are considered and incorporated.

The estates and facilities strategy includes development control plans to demonstrate key strategic developments linked to clinical service delivery, with each development subject to a Board-approved business case.

The reinforced aerated autoclaved concrete (RAAC) element of the West Suffolk Hospital estate is 50 years old with an original design life of 30 years. This continues to be reflected in the high backlog maintenance

costs, with the hospital identified as an outlier in the Model Hospital data from NHS Improvement. In the short to medium term, the Trust faces the challenge of providing a level of care appropriate to the 21st century, within ageing buildings, making it increasingly difficult to meet this challenge. In May 2019 the Standing Committee on Structural Safety (SCOSS) published an alert advising that parts of the structure could be affected by shear failure with very limited warning. The alert related to a significant proportion of the hospital which is constructed of RAAC planks. The Trust has a multi-year programme supported with Public Dividend Capital (PDC) to failsafe the RAAC panels, this supports the mitigation of risk to life but does not reduce the backlog liability. 2024-25 represents the last planned year of capital investment, with future years expected to be ongoing surveying costs and remedial work if an issue is identified.

Having invested in the Newmarket Community Hospital (NCH) infrastructure, the Trust is developing a PDC-funded Community Diagnostic Centre (CDC) on the site through the NHSE Procure23 partnering framework; this project will be completed in November 2024 with patients being treated in December.

Significant schemes planned for delivery include:

- **Newmarket CDC** – to support the national recovery programme in a community setting, the £14.7m scheme has two X-ray rooms, computed tomography (CT) and magnetic resonance imaging (MRI) scanners constructed using modern methods of construction. This scheme also supports the organisation in its journey to digitise the estate in preparation for the new hospital programme scheme on the Hardwick Manor site.
- **imaging equipment** – we have continued to invest in imaging equipment on both the WSH and Newmarket Community Hospital sites. Along with the CDC, we have replaced all mammography equipment, a CT scanner and are completing the replacement of an MRI scanner at the WSH site. The last major investment in this cycle is an MRI scanner planned for replacement in 2025-26.
- **endoscopy equipment** – the programme of scope replacement started in 2023-25 with 11 endoscopes being commissioned, and over the next three years the plan is to replace all four stacks and the remaining fleet of scopes.
- **structural issue** – work has commenced on the RAAC programme with the completion of a number of wards and support areas under year three of a four year programme. We are currently undertaking 'failsafe' supports in ward F6.

Key schemes planned for 2024-25 include:

- ward F6 as above with the plan to complete wards F7 and G4, G5 and the ward G3 corridor in 2024. PDC funding permitting, the programme will be completed at the end of 2024.
- refurbishment of the level three containment room in pathology, a key compliance challenge for the microbiology team.

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

- hot and cold water systems associated with Legionella
- fire compartmentation investment as a result of the updated survey
- electrical infrastructure in operational areas
- sluice room refurbishments
- continue to replacement cooling plant for main theatres.
- ward kitchen refurbishments
- public toilet refurbishments.

Medical devices – the Trust has an allocation within the capital programme to invest in medical device replacement. These are prioritised on a risk-based methodology through the multidisciplinary medical devices group. Where possible, replacement devices are “connected” to maximise the opportunity to interact with and capture data in the patient record to provide an assurance loop of patient safety. Having replaced the high risk and high life risk devices that were overdue investment, we are moving onto the medium life risk items whilst programming the replacement of high risk and high life risk devices as they are due.

Digital – the Trust continues to invest in digital solutions wherever possible to support the digital first but not digital only programme. Improving the network performance and communications across the organisation are central to this along with ensuring investment in cyber security. The digital team is also undertaking extensive replacement of equipment, mainly purchased during the pandemic, that is not Windows 11 compliant.

1.2.5.3 Sustainability

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

To fulfil our responsibilities, WSFT has the following sustainability mission statement in our Green Plan:

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

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

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

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

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

Delivering a ‘Net Zero’ National Health Service October 2020

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

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

Task Force on Climate Financial Rated Disclosures (TCFD)

NHS England’s NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury’s TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2

and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar for 2023-24. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

As the Trust moves to compliance with the above legislation by 2025-26, in 2023-24 we completed a programme of training for the Trust Board to understand their obligations to report on governance, strategy and risk management to tackle climate change and identify key metrics to monitor the Trust's activity.

The annual report and the metrics utilised to monitor our performance support TCFD, and the Trust's Green Plan is the strategy that supports this. We are updating the governance structure of the sustainability net zero group to develop the focus onto wider sustainability and have key sub-groups that support specific workplans (i.e. travel, transport and access, energy) and committees adapted to ensure sustainability forms part of their agenda (e.g. medical gases committee). The changes in accountability for the sustainability net zero group will strengthen the governance for the Board in terms of climate-related issues. The changes will provide management oversight through the management executive group and Board assurance through the insight committee. This will provide regularly oversight to review and monitor organisational plans at an appropriately senior level. The Board has also scheduled a development session on sustainability as part of its programme for 2024-25. This will allow the existing arrangements to be strengthened during the year, ensuring that the Board retains appropriate oversight over its sustainability strategy and plans.

Adaptation

Climate change brings new challenges to the Trust.

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

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

Partnerships

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

Strategic partnerships are already established with the following organisations:

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

Energy

West Suffolk Hospital

Resource		2019-20	2020-21	2021-22	2022-23	2023-24
Gas	Use (kWh)	26,394,446	27,222,128	25,555,792	27,248,895	23,686,716
	tCO ₂ e	5,596	5,656	4,681	5,511	4,324
Oil	Use (litres)	0	0	0	15,639	3,424
	tCO ₂ e	0	0	0	43	9
Electricity	Use (kWh)	5,578,407	5,217,833	5,694,398	4,111,584	6,777,019
	tCO ₂ e	1,946	1,503	1,209	795	1,389
Total energy CO ₂ e		7,542	7,159	5,890	5,949	5,722
Total energy spend		£1,040,357	£1,159,217	£1,515,326	£1,911,066	£2,257,582

Source of data Site readings, invoices and distribution on site

Newmarket Community Hospital

Resource		2021-22	2022-23	2023-24
Gas	Use (kWh)	1,495,016.79	1,622,246.92	1,379,091
	tCO ₂ e	274	328	252
Oil	Use (kWh)	0	0	0
	tCO ₂ e	0	0	0
Electricity	Use (kWh)	489,502.80	494,096	539,124
	tCO ₂ e	103	95	110
Total energy CO ₂ e		377	423	364
Total energy spend		£122,080	£166,583	£193,834

Photovoltaic panels – energy generation at the WSH site

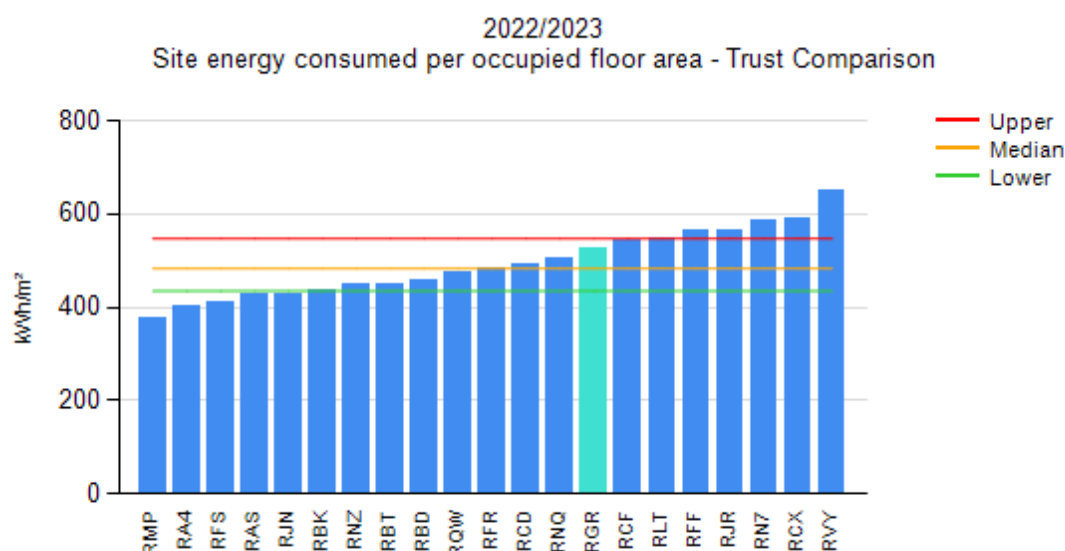
Energy output PV panels (kWh)	2019-20	2020-21	2021-22	2022-23	2023-24
Quince House	10,741	10,891	9,680	10,928	9,645
Accommodation (Beeton, Bloomfield and Clarke)	23,693	27,036	25,309	25,284	20,035
G10	N/A	N/A	10,824	19,758	20,006

2021-2022 data correct at 21-4-22

The Trust joined the Feed-in-Tariff (FIT) scheme and receives an income per kWh generated from the photovoltaic panels placed on Beeton, Bloomfield and Clarke House accommodation. During 2023-24 this has generated an income of £801.

Combined heat and power (CHP) unit

	2019-20	2020-21	2021-22	2022-23	2023-24
Fossil energy input to the CHP system (kWh)	17,176,672	15,971,654	14,023,976	17,308,104	10,231,300
Electrical energy output of CHP system (kWh)	5,501,661	5,128,958	4,557,809	5,665,645	3,361,400
Thermal energy output of CHP system (kWh)	7,272,380	7,479,210	5,761,290	7,427,276	4,524,000



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Paper

Paper (A4)		2019-20	2020-21	2021-22	2022-23	2023-24
Volume used	Tonnes	42	38	39.8	37.8	37.9
Carbon emissions	tCO ₂ e	40	36	29.4	27.9	27.7

The Trust buys recycled A4 paper, so the carbon factor applied in 2023-24 is paper from a closed loop source.

Travel

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

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

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

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

There are a number of electric vehicles in the Trust fleet, including two estates vans, two estates and facilities pool vehicles and a digital services van, each with on-site charging facilities at the West Suffolk Hospital. In spring 2024 the existing public and staff access electric vehicle charge points will be replaced and further charge points will be added.

Business Travel – Agenda for Change and junior doctors

	Mileage	tCO ₂ e*
2019-20	574,593	160
2020-21	402,668	111
2021-22	1,115,310	307
2022-23	1,201,342	330
2023-24	1,366,975	379

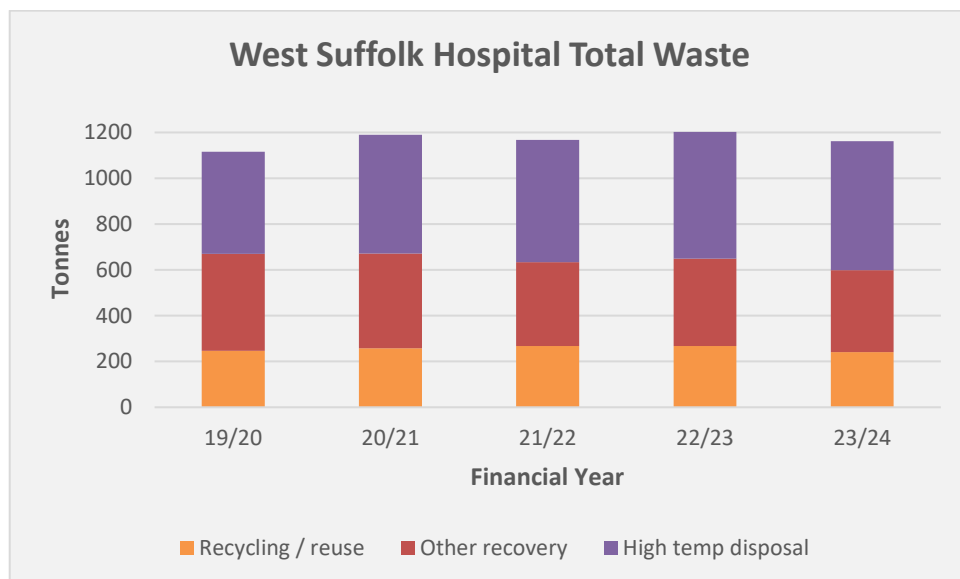
(*BEIS carbon factor 2023 medium car, unknown fuel type 0.27754kgCO₂e/m)

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

Waste		2019-20	2020-21	2021-22	2022-23	2023-24
Recycling/ re-use	(tonnes)	246.1	257.94	268	267	240.44
	tCO ₂ e	5.36	5.5	5.7	5.68	5.11
Other recovery	(tonnes)	423.74	414	366	382	358.49
	tCO ₂ e	9.22	8.82	7.79	8.12	7.62
High temp disposal	(tonnes)	445.54	517.71	533	554	562.77
	tCO ₂ e	98.02	113.90	117.26	*489.98	*507.22
Landfill	(tonnes)	0.00	0	0	0	0
	tCO ₂ e	0.00	0	0	0	0
Total waste (tonnes)		1,115	1,189	1,168	1,203	1162
% Recycled or re-used		22%	22%	23%	22%	21%
Total waste tCO ₂ e		112.60	128.22	130.75	503.78	520.01

Data source – quarterly waste returns, , BEIS carbon factors

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



Data source – quarterly waste returns

Recycling target

Current recycling rate: 21%

Target: 30% by end of 2025-26 financial year.

Recycling streams

The Trust sent 9.17 tonnes of plastic waste for recycling from West Suffolk Hospital and 2.4 tonnes of dry mixed recycling from Newmarket Community Hospital.

The plastic bottle recycling stream at West Suffolk Hospital has been expanded to accept more plastic items for recycling; such as pots, clean food containers and other rigid plastics. This stream has now been rolled out across the majority of non-clinical areas, along with the aluminium recycling stream, predominately for foil and

drinks cans. These streams will be slowly introduced to staff areas in clinical areas for capture of non-clinical plastic and aluminium waste. Work will also be undertaken to move away from the dry mixed recycling waste stream in place at Newmarket, introducing the plastic and aluminium streams as replacements.

The Trust sent 36.4 tonnes of food waste generated from returned patient meals and food preparation for recycling. Plans are in place to make food recycling available in staff kitchen areas. There are also plans to make available a glass recycling waste stream for non-clinical glass waste such as coffee jars.

The circular economy and waste hierarchy

The Trust is committed to driving down the amount of waste created by removing waste from the way we operate. This will be achieved through sustainable procurement and waste avoidance, such as through reuse and refurbishment of existing equipment.

The Trust operates a reuse platform to prevent the procurement of new items and production of waste and keep items in use for longer. In 2023-24, the Trust rehomed 162kgs of equipment.

The Trust sent 2.3 tonnes of waste electronic and electrical equipment (WEEE) on for reuse and 4.4 tonnes of WEEE for recycling, out of a total of 11.39 tonnes collected. The Trust waste management policy outlines our commitment to applying the principles set out in the waste hierarchy. The Trust also partners with a medical device auction company which refurbishes clinical equipment no longer required so it can be reused.

The Trust works with reuse specialists Ramco, a nationwide company which collects items no longer fit for purpose. After refurbishment, these items are auctioned to a network of customers. The Trust ran two projects to upgrade the housekeeping team's cleaning trolleys and also the catering teams hot lock trollies. The old items were collected by Ramco, refurbished and sold on, leading to 112 cleaning trolleys and hot locks being sent for reuse to customers across the UK, instead of disposal.

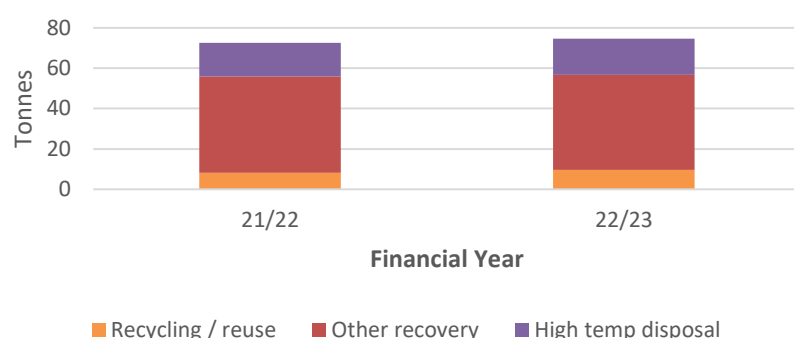
The Trust will continue to implement the waste hierarchy in the months to come, ensuring that waste streams are treated in accordance with their legal minimum requirements. The Trust has successfully rolled out the offensive waste stream at both Newmarket and West Suffolk Hospitals in the year 2023-24, diverting waste previously being sent for high temperature incineration or sterilization, to energy from waste.

Newmarket Community Hospital total waste

Waste		2021-22	2022-23	2023-24
Recycling/ re-use	(tonnes)	8.20	9.63	6.58
	tCO ₂ e	0.17	0.20	0.14
Other recovery	(tonnes)	47.66	47.08	46.15
	tCO ₂ e	1.01	1	0.98
High temp disposal	(tonnes)	16.73	18	17.58
	tCO ₂ e	3.68	*16.22	15.84
Landfill	(tonnes)	0.00	0	0
	tCO ₂ e	0.00	0	0
Total waste (tonnes)		72.58	74.71	70.31
% recycled or re-used		11%	13%	9%
Total waste tCO ₂ e		4.86	17.42	16.96

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

Newmarket Community Hospital Total Waste



Finite resource use – water

West Suffolk Hospital

Water		2019-20	2020-21	2021-22	2022-23	2023-24
Mains water	m ³	111,001	133,409	145,244.22	158,015	184,089
	tCO ₂ e	101	140.34	21.6 (supply) 35.4 (treatment)	23.54 (supply) 36.53 (treatment)	32.58 (supply) 31.45 (treatment)
Water and sewage spend	£	£189,056	£320,387	£333,995	£295,889	£346,364

Source of data - ERIC returns to the Information Centre.

Newmarket Community Hospital

Water		2021-22	2022-23	2023-24
Mains water	m ³	3,402	5,011	4,967
	tCO ₂ e	1.7 (supply) 0.79 (treatment)	0.75 (supply) 1.23 (treatment)	0.88 (supply) 0.84 (treatment)
Water and sewage spend	£	£10,139.99	£16,015.27	£16,103.57

Other initiatives

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

Procurement developments

- embedded social values in all procurement tenders and aiming to introduce annual key performance indicators to track social value elements
- include in procurement tenders the requirement for supplier to publish a carbon reduction plan
- link with SNEE ICB to implement a supplier road map
- introduction of a case study template for sustainability project
- introduction of a sustainability apprentice role.

Community Diagnostics Centre – Newmarket Community Hospital

The Newmarket CDC project is aiming to save 200 tonnesCO₂e through the material procurement and build processes, and collaboration with our supply chain partners. The building's embodied, operational and whole life carbon (also known as the 'building carbon footprint') are tracked using construction partners Morgan Sindall's innovative carbon reduction tool, CarboniCa.

As part of Morgan Sindall's '10 Tonne Challenge', since the start of construction work in 2023, the project team have saved 181.1 tonnesCO2e through:

- installing vibro stone column foundations, which allowed the depth of the concrete foundations to be reduced by one metre in some areas
- using GGBS (ground granulated blast furnace slag) as a partial cement replacement in the concrete used on site, reducing the embodied carbon of the concrete.

CarboniCa will continue to be used to track, reduce and report the CDC's whole life usage.

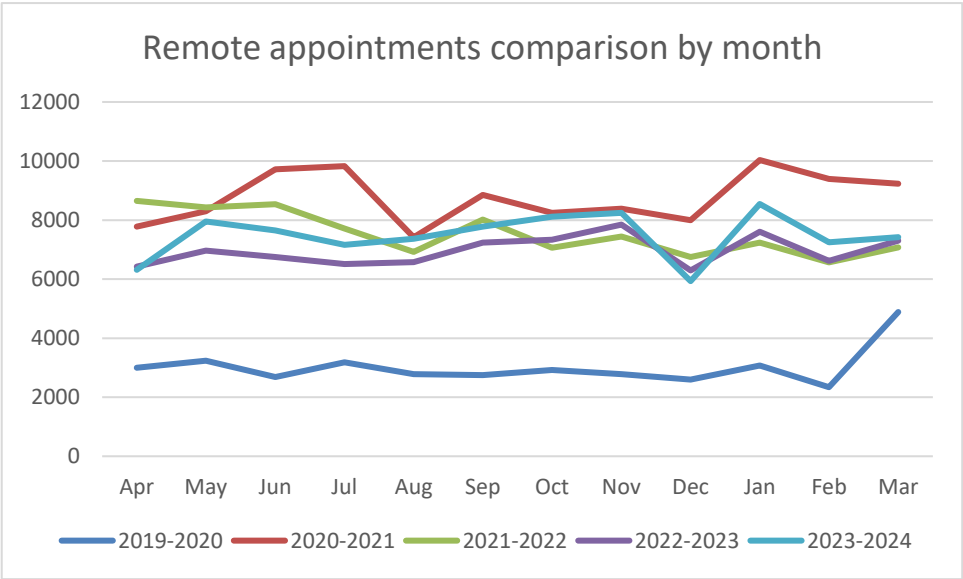
Remote appointments:

The number of remote appointments for patients in 2023-24 was 89,737. The associated benefits, based on the avoidance of the appointments, are:

- 3,470,429 patient miles saved, equivalent to going around the world 130 times
- 1,496 hours of patient time saved through avoided face to face appointments
- 41,506 car park spaces saved.

A reduction of 639.7 tonnes of CO2 emissions (using the outpatient transformation benefits calculator v1 January 2021).

Month	2019-20	2020-21	2021-22	2022-23	2023-24
Apr	2997	7777	8,649	6419	6317
May	3238	8295	8,427	6961	7951
Jun	2683	9720	8,537	6754	7649
Jul	3183	9825	7,712	6509	7166
Aug	2785	7417	6,920	6571	7368
Sep	2753	8856	8,014	7234	7777
Oct	2922	8241	7,059	7331	8112
Nov	2785	8383	7,444	7846	8248
Dec	2600	7991	6,747	6294	5932
Jan	3072	10033	7,238	7605	8545
Feb	2339	9390	6,567	6622	7251
Mar	4885	9227	7,075	7299	7421



1.2.5.4 Equality of service delivery to different groups

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

It is important that as a Trust we are engaging with those who face certain barriers when accessing healthcare services, and who are also less likely to share their views and issues using typical feedback methods. In identifying these barriers, we need to work in co-production with these groups and individuals to overcome these issues and eliminate discrimination and bias.

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

- engagement with a diverse representation of service users on the signage and wayfinding at the Trust
- feedback on the outpatient digital check-in kiosk, specifically engaging with those with communication difficulties
- the addition of diversity questions in all patient surveys to capture data from people with protected characteristics
- promotion of the patient profile to build a better understanding of our patients and their individual needs
- community engagement with underrepresented groups such as those affiliated with supporting protected characteristics including BME Suffolk, Bury Deaf Association, Bury St Edmunds LGBT+ Community, Suffolk Sight and Realise Futures
- connecting with those who have an acquired communication disability and their carers, with regard to reasonable adjustments
- speaking with health inclusion groups in their own environments such as the Gypsy, Roma and Traveller community and attending drop-in sessions at places such as Gatehouse and Bury Drop-in
- cross-alliance working, ensuring information gathered about local communities is shared and that there is better engagement with the locality groups
- growth of our VOICE network to ensure diverse representation
- improving provision of accessible information
- recording a diverse range of patient stories and using these as learning opportunities for staff.

We have also participated in the Equality Delivery System (EDS) 2022 assessing the accessibility of our services for those with protected characteristics. Actions identified will be worked on with service users and staff and reported on in our next submission. The EDS will be run on a rolling programme throughout the year, looking at services across the Trust with a focus on those from the Core20Plus5 (an NHS England approach to reduce health inequalities) in line with health inequalities data.

Our 'belonging in the NHS' group oversees a programme of action to support our staff. Our inclusion workplan sets out our priorities to achieve key objectives for this work. This continues to be developed and strengthened based on insights gained from a range of data sources through which staff have shared their lived experiences. It has seven key workstreams:

- board responsibilities
- recruitment and talent management
- data analysis and reporting
- governance, policies, strategies and guidance
- learning and development
- people processes
- other.

Examples of work we have undertaken this year as identified in our workplan includes:

- committing to delivering the actions required in the Unison Ant-Racism Charter and signing the Inclusive Leadership Pledge
- ensuring equality, diversity and inclusion (EDI) is an objective in all appraisals, including for all Board members
- guidance developed and tested to support Equality Impact Assessments Trust wide
- calendar of events established with activities taking place to celebrate difference throughout the year
- significant work on the development of a Workplace Adjustments Guide for leaders, managers and staff to support disabled colleagues and those with a long-term health condition
- development of digital technology assistive toolkit
- Workforce Race Equality Standard (WRES) data analysed and triangulated with our staff survey and Workforce Disability Equality Standard (WDES) data, enabling further actions to be developed within the Inclusion workplan
- embedding the work of three of our staff networks, and launching a new network:
 - Disability staff network
 - REACH (Race Equality and Cultural Heritage) – a network for Black, Asian and other ethnic minority staff
 - LGBT+ staff network
 - Parent and Carers network – launched in 2024
- continued development of on-line and in person learning and development on EDI topics.

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

2. Accountability report

2.1 Governors' report

2.1.1 Responsibilities

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

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

2.1.2 Composition

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

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

Florence Bevan ⁽¹⁾
Carol Bull ⁽²⁾
Anna Conochie
Allen Drain ⁽³⁾
Val Dutton
Sarah Hanratty
Helen Harlow ⁽⁴⁾
Elizabeth Hodder
Robin Howe ⁽¹⁾
Ben Lord
Gordon Mackay ^{(1) (5)}
Tom Murray
Jayne Neal
Adrian Osbourne
Joe Pajak ⁽⁶⁾
Becky Poynter
Clare Rose
Michael Simpkin
Jane Skinner ⁽⁷⁾
Liz Steele ⁽¹⁾
Clive Wilson ⁽¹⁾

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

Anna Clapton (nee Mills)
John-Paul (J-P) Holt
Louisa Honeybun
Sarah Judge ⁽¹⁾
Amanda Keighley ⁽¹⁾
Andy Morris
Adam Musgrove
Martin Wood ⁽¹⁾

Partner governors – nominated by partner organisations of WSFT

Councillor Carol Bull ⁽²⁾	West Suffolk Council also representing Mid Suffolk District Council and Babergh District Council
Councillor Heike Sowa ⁽⁸⁾	Suffolk County Council
Dr David Brandon	West Suffolk Alliance
Vacant (second representative)	SNEE ICB in consultation with local general practitioners and West Suffolk Alliance
Councillor Rebecca Hopfensperger ⁽⁸⁾	West Suffolk Council
Councillor Richard O'Driscoll ^{(8) (9)}	West Suffolk Council
Councillor Rowena Lindberg ⁽¹⁰⁾	West Suffolk Council
Elsbeth Lees	University Campus Suffolk (UCS) in consultation with West Suffolk College
Dr Thomas Pulimood	University of Cambridge
David Smith ⁽¹¹⁾	Volunteers and Friends of West Suffolk Hospital
Sue Kingston ⁽¹²⁾	Volunteers and Friends of West Suffolk Hospital

Notes:

- (1) Governor until elections November 2023
- (2) Carol Bull elected as public governor in December 2023
- (3) Allen Drain resigned from Council of Governors in April 2023
- (4) Helen Harlow resigned from Council of Governors in February 2024
- (5) Gordon Mackay appointed to Council of Governors from March 2024
- (6) Joe Pajak resigned from Council of Governors in May 2023
- (7) Jane Skinner Lead Governor from January 2023
- (8) New governor nominated December 2023
- (9) Richard O'Driscoll stepped down in March 2024
- (10) Rowena Lindberg nominated on Council of Governors in March 2024
- (11) David Smith resigned from Council of Governors in January 2024
- (12) Sue Kingston nominated on Council of Governors in March 2024

Governor attendance at Council of Governors' meetings 2022-23

There were seven formal meetings of the Council of Governors: 2 May 2023; 2 June 2023 (held in private); 4 September 2023; 26 September 2023 (Annual Members Meeting); 26 October 2023 (held in private); 7 November 2023; and 27 February 2024.

The following governors were in attendance (note that attendance at AMM is not included in figures below):

Name	Title	Attendance (out of six meetings)
Florence Bevan ⁽¹⁾	Public governor	5 (of 5)
Dr David Brandon	Partner governor	3 (of 6)
Carol Bull ⁽²⁾	Public governor	4 (of 6)
Anna Clapton (nee Mills)	Staff governor	0 (of 1)
Anna Conochie	Public governor	1 (of 1)
Allen Drain ⁽³⁾	Public governor	0 (of 0)
Val Dutton	Public governor	1 (of 1)
Sarah Hanratty	Public governor	1 (of 1)
Helen Harlow ⁽⁴⁾	Public governor	0 (of 0)
Elizabeth Hodder	Public governor	1 (of 1)

Name	Title	Attendance (out of six meetings)
John-Paul (J-P) Holt	Staff governor	1 (of 1)
Louisa Honeybun	Staff governor	5 (of 6)
Councillor Rebecca Hopfensperger ⁽⁸⁾	Partner governor	5 (of 5)
Robin Howe ⁽¹⁾	Public governor	3 (of 5)
Sarah Judge ⁽¹⁾	Staff governor	4 (of 5)
Amanda Keighley ⁽¹⁾	Staff governor	4 (of 5)
Sue Kingston ⁽¹²⁾	Partner governor	0 (of 0)
Elspeth Lees	Partner governor	6
Councillor Rowena Lindberg ⁽¹⁰⁾	Partner governor	0 (of 0)
Ben Lord	Public governor	6
Gordon Mackay ^{(1) (5)}	Public governor	3 (of 5)
Andy Morris	Staff governor	1 (of 1)
Adam Musgrove	Staff governor	1 (of 1)
Tom Murray	Public governor	1 (of 1)
Jayne Neal	Public governor	6
Councillor Richard O'Driscoll ^{(8) (9)}	Partner governor	0 (of 1)
Adrian Osbourne	Public governor	5 (of 6)
Joe Pajak ⁽⁶⁾	Public governor	1 (of 1)
Becky Poynter	Public governor	1 (of 1)
Dr Thomas Pulimood	Partner governor	6
Clare Rose	Public governor	1 (of 1)
Michael Simpkin	Public governor	1 (of 1)
Jane Skinner ⁽⁷⁾	Public governor	5 (of 6)
David Smith ⁽¹¹⁾	Partner governor	0 (of 0)
Councillor Heike Sowa ⁽⁸⁾	Partner governor	1 (of 1)
Liz Steele ⁽¹⁾	Public governor	5 (of 5)
Clive Wilson ⁽¹⁾	Public governor	4 (of 5)
Martin Wood ⁽¹⁾	Staff governor	3 (of 5)

Notes:

- (1) Governor until elections November 2023
- (2) Carol Bull elected as public governor in December 2023
- (3) Allen Drain resigned from Council of Governors in April 2023
- (4) Helen Harlow resigned from Council of Governors in February 2024
- (5) Gordon Mackay appointed to Council of Governors from March 2024
- (6) Joe Pajak resigned from Council of Governors in May 2023
- (7) Jane Skinner Lead Governor from January 2023
- (8) New governor nominated December 2023
- (9) Richard O'Driscoll stepped down in March 2024
- (10) Rowena Lindberg nominated on Council of Governors in March 2024
- (11) David Smith resigned from Council of Governors in Jan 2024
- (12) Sue Kingston nominated on Council of Governors in March 2024

In attendance at these meetings were: Craig Black, executive director of resources/deputy chief executive (1 of 1); Ewen Cameron, chief executive (4 of 6); Jude Chin, non-executive director/chair (6 of 6); Tracy Dowling, non-executive director (3 of 5); Antoinette Jackson, non-executive director (4 of 6); Louisa Pepper, non-executive director (4 of 6); Geraldine O'Sullivan, non-executive director (1 of 6); Jeremy Over, executive director of workforce and communications (1 of 1); Krishna Yergol, non-executive director (2 of 6).

2.1.3 Register of interests

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

2.1.4 Governors and directors working together

Governors and directors have developed a professional working relationship, on both a formal and informal basis. Governors attend and observe the monthly Board of directors' meetings. This gives them an insight into and an understanding of the performance of the Board, particularly from a quality and finance perspective, and provides an insight into the role and performance of the non-executive directors (NEDs). At the start of 2023 Governors were invited to act as observers at the three assurance committees of the Board – the insight, involvement and improvement committees of the Board.

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

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

A joint governor and NED training session took place on 30 January 2024 and to support governors in their role a range of joint board/governor briefings took place during 2023-24:

- 25 April 2023 - operational planning guidance
- 28 June 2023 - living the Trust values session
- 7 Aug 2023 - Future Systems programme
- 18 Oct 2023 - complaints and PALS
- 29 April 2024 – virtual ward update.

Induction sessions were organised for newly elected council of governors:

- 18 Dec 2023 – governors' induction session
- 11 Jan 2024 - introduction to finance
- 18 Jan 2024 – patient quality and safety.

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

To support governors in engaging with staff, patients and the public they take part in activities including quality and environmental walkabouts, area observations and engagement sessions in the WSH Courtyard Café.

The engagement committee, which is a sub-committee of the Council of Governors, meets quarterly and a report on the committee's activities is provided to the Council of Governors.

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

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

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

2.1.5 Membership

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

Public membership

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

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

Staff membership

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

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. This does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

Membership numbers

On 31 March 2024 there were 6,552 public members and 5,461 staff members.

Membership

Our foundation trust membership is reviewed by the engagement committee. We aim to maintain and, where possible, increase our public membership and to ensure that staff membership is maintained at an appropriately high level. Experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views.

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

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

During the year the Trust reinstated its membership interest events on the services we provide, including looking after your heart (July 2023) and legs matter (May 2024). The Annual Members Meeting was held at the Apex in Bury St Edmunds in September 2023.

Contact procedures for members

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

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

2.1.6 Nominations committee

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

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

In June 2023, following a comprehensive interview process for substantive chair, the committee presented a report to the Council of Governors recommending the appointment of Jude Chin as the substantive Trust Chair of West Suffolk NHS Foundation Trust for a three-year term ending on 1 June 2026. The recommendations were agreed at a closed Council of Governors meeting on 2 June 2023.

In July 2023, the committee reviewed the feedback from the appraisals of the NEDs and key messages were fed back to each individual.

In March 2024, the committee met to discuss the process and timetable for the recruitment of NEDs to fill existing and future vacancies. The committee met in May 2024 to longlist potential candidates for the NEDs position and subsequently in June to shortlist candidates for interview.

Attendance at nominations committee meetings 2023-24

Name	Title	Attendance (out of 4)
Jude Chin (chair)	Chair	4 (of 4)
Carol Bull	Partner governor	4 (of 4)
John-Paul Holt ⁽¹⁾	Staff governor	1 (of 1)
Ben Lord	Public governor	4 (of 4)
Andy Morris ⁽¹⁾	Staff governor	1 (of 1)
Jayne Neale	Public governor	4 (of 4)
Adrian Osborne ⁽¹⁾	Public governor	1 (of 1)
Thomas Pulimood ⁽¹⁾	Partner governor	1 (of 1)
Jane Skinner	Public governor	4 (of 4)
Heike Sowa ⁽¹⁾	Partner governor	0 (of 1)
Liz Steele ⁽²⁾	Public governor	3 (of 3)
Clive Wilson ⁽²⁾	Public governor	2 (of 3)
Martin Wood ⁽²⁾	Staff governor	3 (of 3)

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

⁽¹⁾ Committee member from February 2024

⁽²⁾ Committee member until November 2023

Meeting dates: 24 April 2023; 12 July 2023; 19 October 2023; 11 March 2024.

Shortlisting/longlisting discussions: 11 May 2023 (Chair shortlisting); 16 May 2024 (NED longlisting); 4 June 2024 (NED shortlisting).

2.2 Directors’ report

2.2.1 Responsibilities

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

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

Disagreements between the Board of directors and Council of Governors are resolved through a process which aims to achieve informal resolution in the first instance, following which a formal process will be taken that involves a resolution for discussion at a Board meeting. The Trust introduced the policy for engagement between the Trust Board and the Council of Governors in 2023 which describes the methods by which governors can engage with the Board of directors when they have concerns about the Board’s performance, the compliance with the provider terms of authorisation or the welfare of the Trust.

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

<p>Jude Chin - Non-executive director and chair <i>(Appointed on a three-year term from 2 June 2023)</i></p> <p>Areas of special interest/responsibility: Jude is chair of the Board of directors and chair of the Council of Governors of WSFT. He is also chair of the remuneration committee of the Board and chair of the governors’ nominations, appointments and remuneration committee.</p> <p>Previously, Jude was vice-chair of Colchester Hospital University NHS Foundation Trust and a partner at KPMG.</p> <p>Independent director – yes (satisfies criteria of code of governance B. 2.6)</p>
<p>Antoinette Jackson: Non-executive director and senior independent director <i>(Appointed from 1 November 2022)</i></p> <p>Areas of special interest/responsibility: chair of the insight committee, member of the remuneration committee, audit committee, involvement committee and charitable funds committee, lead NED Board freedom to speak up guardian, including whistleblowing.</p> <p>Antoinette has a background in local government and was the chief executive of Cambridge City Council between 2009 and 2020. She began her career at Reading Borough Council before joining the London Borough of Camden in roles focusing on quality and customer services. Antoinette is also chair of trustees for Arthur Rank Hospice Charity and Cambridge and District Citizens Advice.</p> <p>Antoinette was appointed as senior independent director in April 2023.</p> <p>Independent director – yes (satisfies criteria of code of governance B. 2.6)</p>

Louisa Pepper - Non-executive director and deputy chair

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

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

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

Louisa is an elected parish councillor for Thorpe Morieux.

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

Dr Roger Petter (University of Cambridge nominated NED)

(Appointed term 1 March 2023 – 28 February 2026)

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

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

Independent director – yes (see Note 1)

Michael Parsons - Non-executive director (Appointed from 1 May 2023)

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

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

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

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

Independent director – yes

Note 1

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

Non-executive directors who left the Trust

Dr Geraldine O'Sullivan: Non-executive director

(Appointed from 1 November 2022 until April 2024)

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

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

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

Tracy Dowling: Non-executive director

(Appointed from 1 November 2022 and stepped down 17 November 2023 on to take-up interim Chief Executive role at Mid and South Essex ICB. Tracy will re-join the WSFT Board on 1 August 2024)

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

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

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

Krishna Yergol: Non-executive director

(Appointed from 1 November 2022 until April 2024)

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

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

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

(b) Executive directors

Craig Black – executive director of resources and deputy chief executive (from February 2023)

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

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

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

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

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

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

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

He was previously interim chief operating officer, divisional director, director of the Cambridge Bowel Cancer Screening Centre and clinical lead for endoscopy over his 17 years as a consultant gastroenterologist at Cambridge University Hospitals NHS Foundation Trust.

Ewen has 28 years of experience within the NHS. Having graduated from the University of Cambridge he has worked in hospitals across the East of England and the East Midlands.

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

Areas of responsibility: executive lead (with director of resources) for insight committee, executive lead for delivery of NHS operational standards, chair of urgent and emergency care performance governance group, accountable officer for emergency planning, chair of investment panel, chair of workforce resource group, executive lead for change and transformation teams, executive sponsor for PRIDE network, Trust representative at integrated care partnership, strategic sponsor for Stay Well domain in West Suffolk Alliance, co-lead (with director of resources) for delivery of the First for the future ambition of the Trust strategy, senior responsible officer for East Coast Pathology Network, senior responsible officer for Eastern Physiological Sciences Network

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

Jeremy Over – executive director of workforce and communications (from November 2019)

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

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

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

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

Areas of responsibility: professional leadership for doctors, responsibility for undergraduate and post graduate medical education, Trust responsible officer, responsibility for Caldicott Guardian, mortality oversight group, medical examiners, executive responsibility for quality improvement, joint operational responsibility with executive chief nurse and chief operating officer for operational management and delivery of all services, responsibility for public health team, liaison with primary care through local negotiating committee (LNC), delivery of the clinical and care strategy.

Prior to being appointed medical director in June 2021, Paul has been a consultant neurologist at WSFT and Cambridge University Hospitals since 2003. He has previously held roles of clinical lead for neurology, clinical director for specialist medicine, deputy medical director and secondary care specialist at North-east Essex CCG.

Susan Wilkinson – executive chief nurse (from June 2020)

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

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

Sue has been in post since June 2020.

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

During 2023-24 Clement Mawoyo, director of integrated adult health and social care, which is a joint appointment funded by WSFT and Suffolk County Council and Peter Wightman West Suffolk Alliance director, which is a joint appointment funded by SNEE ICB, attended WSFT Board meetings on a regular basis.

2.2.3 Register of interests

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

2.2.4 Appointment of chair and non-executive directors

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

The nomination, appointments and remuneration committee of the Council of Governors makes a recommendation for appointment for a non-executive director to the Council of Governors. This committee comprises the chair of WSFT, five public governors (including the lead governor), two staff governors and two partner governors. 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 open competition 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 2023-24

Name	Title	Attendance (out of 6)
Jude Chin ^(a)	Chair	6
Ewen Cameron ^(b)	CEO	6
Craig Black ^(c)	Executive director of resources	6
Nicola Cottington	Chief operating officer	5 (of 6)
Jeremy Over	Executive director of workforce and communications	5 (of 6)
Paul Molyneux	Executive medical director	6
Susan Wilkinson	Executive chief nurse	6
Louisa Pepper	Non-executive director/deputy chair	4 (of 6)
Krishna Yergol ^(d)	Non-executive director	6
Geraldine O'Sullivan ^(e)	Non-executive director	4 (of 6)
Antoinette Jackson	Non-executive director/senior independent director	5 (of 6)
Roger Petter	Non-executive director	4 (of 6)
Michael Parsons ^(f)	Non-executive director	6
Individuals no longer on the Board		
Tracy Dowling ^(g)	Non-executive director	3 (of 3)

- a) Jude Chin appointed as chair on fixed term contract in June 2023
- b) Ewen Cameron appointed as CEO 20 Feb 2023
- c) Craig Black returned to role of executive director of resources on 20 Feb 2023, from interim CEO
- d) Krishna Yergol stepped down from the role with effect from (w.e.f) 30 April 2024
- e) Geraldine O'Sullivan stepped down from the role w.e.f. 30 April 2024
- f) Michael Parsons appointed as non-executive director 1 May 2023
- g) Tracy Dowling appointed as non-executive director on 1 Nov 2022 and stepped down on 17 Nov 2023

Meeting dates: 26 May 2023; 21 July 2023; 29 September 2023; 1 December 2023; 26 January 2024; and 22 March 2024.

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

2.2.6 Committees of the Board

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

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

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

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

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

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

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

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

Each board committee reviews its terms of reference and undertakes a review of its effectiveness at least annually.

Insight Committee - attendance 2023-24

Name	Title	Attendance (out of 11)
Antoinette Jackson	Non-executive director and chair	11
Louisa Pepper	Non-executive director	9 (of 11)
Dr Roger Petter <i>(from 01/05/23)</i>	Non-executive director	7 (of 10)
Michael Parsons <i>(from 01/05/23)</i>	Non-executive director	6 (of 10)
Krishna Yergol <i>(until 01/05/23)</i>	Non-executive director	1 (of 1)
Craig Black	Director of resources / deputy CEO	10 (of 11)
Nicola Cottington	Chief operating officer	8 (of 11)
Dr Paul Molyneux	Medical director	4 (of 11)
Sue Wilkinson	Chief nurse	10 (of 11)

The chief executive is not a member but has an open invitation to attend meetings of the committee – attending nine of 11 meetings.

Involvement committee - attendance 2023-24

Name	Title	Attendance (out of six)
Tracy Dowling <i>(until Nov 2023)</i>	Non-executive director and chair	4 (of 4)
Antoinette Jackson	Non-executive director	5 (of 6)
Geraldine O'Sullivan	Non-executive director	3 (of 6)
Krishna Yergol <i>(from Dec 2023)</i>	Non-executive director and chair	2 (of 2)
Craig Black	Director of resources / deputy CEO	1 (of 6)
Nicola Cottington	Chief operating officer	5 (of 6)
Jeremy Over	Director of workforce and communications	6
Dr Paul Molyneux	Medical director	2 (of 6)
Sue Wilkinson	Chief nurse	4 (of 6)

The chief executive is not a member but has an open invitation to attend meetings of the committee – attending three of six meetings.

The attendance figures above include attendance by deputies: Kaushik Bhowmick, deputy medical director (1) and Matt Keeling, deputy chief operating officer (1)

Improvement committee - attendance 2023-24

Name	Title	Attendance (out of 11)
Tracy Dowling	Non-executive director	6 (of 7)
Geraldine O'Sullivan	Non-executive director	10 (of 11)
Louisa Pepper	Non-executive director and chair	10 (of 11)
Dr Roger Petter	Non-executive director	8 (of 11)
Craig Black	Executive director of resources / deputy CEO	10 (of 11)
Nicola Cottington	Chief operating officer	10 (of 11)
Dr Paul Molyneux	Medical director	7 (of 11)
Jeremy Over	Director of workforce and communications	8 (of 11)
Sue Wilkinson	Chief nurse	10 (of 11)

The chief executive is not a member but has an open invitation to attend meetings of the committee – attending nine of 11 meetings.

The attendance figures above include attendance by deputies: Ravi Ayyamuthu, deputy medical director (1) and Carol Steed, deputy director of workforce (2).

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 England (NHSE) in exercise of powers conferred on it by paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006.

External audit

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

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

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

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

The Council of Governors in its closed session on 7 November 2023 approved the extension of the contract with external auditors for up to two further years.

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 2023-24.

Internal audit

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

System of internal control

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

realised, and to manage them efficiently, effectively and economically.

Attendance at audit committee meetings

Name	Title	Attendance (out of 4)
Michael Parsons <i>(from May 2023)</i>	Non-executive director / chair	4
Antoinette Jackson	Non-executive director / senior independent director	4
Louisa Pepper	Non-executive director/deputy chair	1 (of 4)
Tracy Dowling <i>(until Nov 2023)</i>	Non-executive director	1 (of 2)
Krishna Yergol <i>(from Dec 2023)</i>	Non-executive director	2 (of 2)

All NEDs were invited to attend audit committees (including deep dive presentations) but only those specified above are members of the committee. Meeting dates: 27 June 2023, 20 September 2023, 12 December 2023, 19 March 2024.

2.2.7 Well-led framework

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

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

The Board of directors reviews the arrangements in place to deliver quality as part of the annual governance review it undertakes. This includes a review of relevant assurances within the board assurance framework. Further details of the structure are provided in the annual governance statement (section 2.6).

In line with good governance practice, during 2023-24 the Board commissioned ConsultOne (the consultancy arm of AuditOne) to undertake a well-led developmental review of leadership and governance at the Trust. The review took place between December 2023 and March 2024, to inform further development work to support continuous improvement of our governance arrangements.

The review process included documentary assessment, interviews with Board members, members of staff, governors and external stakeholders as well as meeting observations for the Board and its committees, Council of Governors and operational management meetings.

The final report was issued in May 2024 and highlight well-led strengths and areas of further focus by the WSFT Board. An improvement plan to address the findings of the report is being prepared which will be structured around the recent CQC well led guidance.

2.2.8 Details of consultation

Local groups and the public and patient involvement activities

VOICE

The VOICE network continues to grow, with a diverse membership representing patient support groups and charities in the local community. Members' feedback from their respective groups and their input into developments at the Trust, ensures service user involvement whilst also providing groups with ongoing opportunities to support patient experience improvement initiatives.

Groups with which we have engaged include:

- Chronic Pain Support Group
- Lymphoedema Support Group
- Upbeat Heart Support Group
- Parkinson's Support Group
- Time Out Carer's Support Group
- Alzheimer's Society
- Bury Deaf Association
- BME Suffolk
- Suffolk User Forum
- Bury St Edmunds LGBT+ Community
- SALT Communication Hub.

Engagement with local groups is ongoing.

Public health

It is vital that we are engaging with those who face barriers when accessing healthcare services, and who are also less likely to share their views and issues using typical feedback methods.

Our engagement work is planned with the CORE20PLUS5 determinants in mind, ensuring focus on groups that suffer health inequalities in our localities to reduce these gaps.

As part of this work, we have engaged with the Suffolk Refugee Support group in Ipswich, to better understand the needs of the refugee community they support. Following their feedback about areas the group would like to better understand, a session is booked in May 2024 for a member of the public health team to talk to the group about hypertension.

Public engagement activities

As part of the patient experience and engagement team's commitment to proactively engage with people and provide opportunities for service users and the community to provide feedback, the team have attended local events such as Wellbeing Wednesdays organised by Norfolk and Suffolk NHS Foundation Trust, Gatehouse drop-in events supporting those with material and emotional need in Suffolk, and dementia/carers' cafés.

All feedback gathered from any of our engagement activity is collated centrally with actions identified and worked on.

Across the West Suffolk Alliance, the team work collaboratively with engagement colleagues within SNEE ICB, Suffolk County Council, Community Action Suffolk, Healthwatch Suffolk and others.

Healthwatch Suffolk

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

- phlebotomy
- children's outpatients
- antenatal and gynaecology outpatients.

Feedback obtained from these sessions has been shared with leads of these areas and compared against Patient Advice and Liaison Service (PALS) and complaints data.

Public involvement activities

The team has ensured that the collection of patient and carer stories covers a wide range of experiences and includes those with a protected characteristic. These stories are presented at key meetings across the Trust and will be used on the Totara learning hub for staff development. Those who share their stories are told where their stories have been shown, as well as what actions and learning have been identified.

Stories recorded include experiences of:

- patients with a learning disability
- a young person
- elderly patients in the community
- family carers
- a deaf patient.

Members of the public were involved in reviewing the outpatient department digital check-in kiosk before its launch in January 2024. Feedback was provided regarding its accessibility which included several suggested alterations, which the digital team have been working through.

Future events

Experience of Care Week will take place from 29 April to 3 May 2024; this is an international initiative to celebrate work that is happening across healthcare services to improve patient experience.

A key focus of the team's public engagement work is taking place from 20 May to 30 June 2024. Alongside clinical colleagues and members of SNEE ICB communication team, the patient experience and engagement team will be speaking to members of the public about the proposal to move a percentage of planned orthopaedic operations, for people 18 and over, each year from West Suffolk NHS Foundation Trust to the Essex and Suffolk Elective Orthopaedic Centre (ESEOC).

Feedback is being collated through an anonymous survey being run by Healthwatch Suffolk, which will also be responsible for analysing feedback received to help the NHS make the best decisions for the community.

Public events, pop-up stands and posters with a link to the Healthwatch survey will be organised and displayed in rural areas and areas of deprivation across west Suffolk.

Future System programme

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

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

- those with learning disabilities
- those with severe mental health requirements
- homeless and rough sleeper community
- young adults and students
- clinical patient support groups
- Romany, Gypsy and traveller community
- staff
- patients who have suffered a stroke or care for someone who has
- Women's Institutes
- resident associations
- local councils and councillors.

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

Duty to involve

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

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

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

Engagement activity

Overview

Emphasis needs to be placed on the quality of output rather quantity of interactions however key stats for 2023-24 include:

- more than 3,194 people spoken with
- 32 face to face engagement sessions
- 32 online engagement sessions
- 33 co-production workshops
- 468 resident letters sent.

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

Programme stakeholder engagement

Over the course of 2023–2024 the programme has hosted stakeholder engagement activities including:

The Secretary of State for Health and Social Care

The Secretary of State for Health and Social Care, Rt Hon Steve Barclay MP, visited West Suffolk NHS Foundation Trust (WSFT) on Thursday 25 May. The visit was following the Government's commitment to prioritising the replacement of hospitals containing Reinforced Autoclaved Aerated Concrete (RAAC), including West Suffolk Hospital based in Bury St. Edmunds.

Steve Barclay, alongside Jo Churchill, Member of Parliament for Bury St Edmunds, received a tour of the current hospital, including areas affected by RAAC, and spoke to members of staff.

Parliamentary Under Secretary of State, Department of Health and Social Care, Lord Markham CBE

The Parliamentary Under Secretary of State, Department of Health and Social Care, Lord Markham CBE, visited the Trust twice in 2023-24. The Minister has responsibility for NHS capital, land and estates, including the New Hospital Programme, at the Department of Health and Social Care.

The first visit was on Tuesday 8 August. This included a discussion with system-wide representatives, another with programme and co-production leads, a tour of the acute hospital including our ongoing RAAC maintenance works and our development site, and speaking to members of staff.

In February 2024 the Trust received a second visit from Lord Markham, along with local MPs Jo Churchill and James Cartlidge. The group visited the development site for the replacement West Suffolk Hospital and viewed the archaeological trial trenching in progress along with the plans for the buffer planting.

Lord Markham planted the first in a series of buffer trees which will mitigate the visual and sound impact of the proposed new hospital and is a part of important enabling works to prepare the site for the new hospital.

Estate

The team continue to engage with local residents regrading key estates milestones including:

- the translocation of turfs
- the commencement of buffer planting
- the activity of archaeological trial trenching.

Engagement has been in the form of in-person resident meetings and direct communication.

Clinical services

The development of the clinical model for the new hospital is led by 12 co-production workstreams, recruited from the WSFT workforce.

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

The clinical team has focused on ratifying the designs developed through co-production, reconciling them with national standards and expectations shared by the New Hospital Programme team.

Retail and public spaces engagement

Public and staff engagement was delivered focusing on public and retail spaces including waiting rooms, foyers, café's for both patients and staff as well as shops and other spaces. The engagement built on both primary and secondary qualitative and quantitative research and best industry practice. A variety of methods focusing on key stakeholders was used.

The key points and recommendations from the engagement contributed to these strategic objectives:

- increase revenue for the Trust
- improve staff wellbeing and morale thus improving staff retention
- improve staff recruitment making WSFT an employer of choice
- positively impact the quality and safety of care delivered to patients
- positively impact the quality of care delivered by carers and those with caring responsibilities.

Whilst also adhering to our Trust values of being first for patients, first for staff and first for the future.

Key findings included:

- access to hot food 24/7
- the purpose of refreshment facilities was not just to rehydrate but was a meeting space for colleagues, a space for patients to eat away from their beds and a location for carers to refuel.
- accessible free drinking facilities
- items suitable for all dietary requirements including aphasia friendly items
- healthier food choices available
- refreshment facilities located near to key departments.

The retail engagement results were shared with the WSFT Estates team to inform their business as usual strategies and their preferred requirements within the 1:200 designs for the new hospital.

Both the public spaces engagement results and a copy of the retail engagement results were also shared with the clinical workstream to help inform their 1:200 designs.

Equalities impact engagement

The work to understand the current situation and the status quo has been completed. The work seeks to understand how people travel, who they travel with and where they travelled from. This work provided a gap analysis to identify any opportunities to rectify problems and make things better for patients, and received nearly 1,200 responses.

The survey was shared and publicised via social media, press release to local media, text messages to identified patients, emails to community engagement group members, posters in clinic areas, face to face surveys carried out in clinic areas. Paper surveys are available in clinics and at the front reception desk.

As well as information relating to how patients travel and with whom, the survey also captured equalities and impacts too, particularly those that people do not recognise they have/they are. These findings informed our equalities impact assessment for the outline business case.

To substantiate the quantitative results qualitative discussions were also held with:

- carers
- those experiencing loneliness
- those on a lower income
- those experiencing and representing disabilities
- youth members
- parents
- specific support groups (SANDS neonatal bereavement, chronic pain, speech and language therapy)
- Gypsy, Traveller and Roma traveller sites and communities.

The key results were:

Location of services

- a majority of patients travel by car meaning that, as long as there is good parking availability, then patients can be reasonably expected to attend appointments in a new location
- those who are self-employed, care for individuals including relatives/neighbours unofficially and children, would welcome services closer to their homes due to reducing time travelling and loss of earnings / time off from work, reduced time required for childcare
- 81% would prefer to travel to a new location within a three-mile radius if it meant receiving treatment sooner
- 21% would prefer to continue to receive treatment at the current Hardwick Lane site even if it meant waiting longer.

Travel

- at least 66% of respondents had travelled to an area of Bury St. Edmunds by car, whether driving themselves or being driven
- 63% of respondents did not work but of those who did, 12% travelled at least 15+ miles to work, and for 29% this was five days a week, leading to the assumption that they would be willing to travel to a healthcare appointment if required
- many respondents did experience difficulties when travelling including mobility, lack of public and/or community transportation and requiring family, friends and/or neighbours to assist them to get to their appointments making attending appointments difficult
- ease of travel was very much dependent on traffic upon the route, availability of parking, availability of public and/or community transportation and accessibility particularly blue badge parking arrangements for disabled drivers
- 41% of those travelling to the West Suffolk Hospital use the A14 junctions 43, 44 or 45
- 9% (73) respondents travelled via the Westley direction
 - it is important to note that this does not necessarily mean junction 42 was used. Only four respondents explicitly stated J.42, however there are several routes via Westley/Newmarket Road to the hospital
 - this is important to note due to the limited number of patients travelling to WSFT via this direction (that is not to say that they would not travel there if their appointment was at the location).

Appointments

- 89% would find attending an appointment at the weekend easier or as easy as attending an appointment during the week (Monday to Friday). This was due to: work commitments, the expectation of less traffic and easier park, childcare availability allowing them to attend the appointment, family and friends being able to take them to appointments and for those who were self-employed not losing income / less of a requirement to book annual leave for an appointment. However, those who relied on public transport and/or community transport such as E-zek would not find this easier (11%) and would be unable to make the appointment.

Digital

- 98% of responders had access to the internet. These individuals also stated that they found travelling to appointments easy
- 1% accessed the internet via public places such as libraries and internet cafes. This 1% also stated that they travelled further than they would have liked for an appointment
- 83% of responders stated they felt quite or very confident using the internet
- 16% of responders required assistance with the internet. 1% did not have access to the internet which corresponds with the previous 1% in responses
- 29% would prefer to receive treatment virtually if it meant receiving treatment/appointment sooner.

Other elements to consider (substantiated by qualitative community engagement rather than quantitative survey data)

- those who are already disadvantaged may be disadvantaged further by a move of services unless mitigation is put in place regarding public transport and the ability to plan their journey without access to the internet
- if a move of services is accompanied by adequate travel routes, parking and parking fees then a move of services may be positively received
- anecdotally, community members rate Newmarket and Mildenhall highly. The view of Mildenhall is impacted considerably by the ability to access services during school pick up times particularly due to parking, traffic and the location of the disabled parking spaces (situated at the back of the car park causing individuals to have to walk a great distance to the entrance – electrical car charging points were placed by the entrance)
- the times when appointments are available, including evenings and weekends, and parking availability, was more important than the location of the services though this disadvantaged those who relied on public and/or community transport
- a majority of the females spoken to had a driving licence and previously drove themselves to work, defaulting to their husband and/or partner driving when they were together. Upon retirement they were together more leading to females driving less and losing their confidence. Typically, mortality suggests that males die sooner, leaving a widowed female without the confidence to drive and limited public transport options to the hospital. Whilst we have an ageing population, this predicament is not expected to change. Our current 'young' demographic will increase in age and become 'old' and the same stereotypical driving roles are still expected to apply
- several recent reports have provided evidence that females aged between 30 and 45 – are at a turning point, a 'guinea pig' generation, as they are working fulltime in greater numbers than previous generations, yet typically they also carry the majority of the household workload, and, combined with having children later, are in a perfect triumvirate storm of looking after young children, looking after elderly relatives including their own parents and/or in-laws as well as hitting the perimenopause. This engagement evidenced that this generation were de-prioritising their healthcare. By making healthcare more accessible, particularly the time of appointments and/or location of services, would improve this.

All the findings were fed into the schedule of accommodation, working with the co-production clinical workstream leads to truly co-produce the design of our new hospital and impact on patient outcomes and hospital productivity.

Digital engagement

The digital engagement concluded at the end of 2023.

The following number of workshops were held:

- 15 public in person workshops
- 2 online workshops
- 16 staff workshops (in person and online).

Nearly 700 people responded to the survey (online, paper and aphasia friendly version) and we spoke to approximately 450 people in person.

The engagement covered the whole West Suffolk catchment area.

Our engagement addressed those identified within the original stakeholder matrix as being cohorts impacted the most. These included but were not limited to:

- those from a low income
- carers
- sole occupants
- people aged over 65
- younger generation aged two to 10 years
- adolescents aged 11 to 16 years
- parents.

Key learnings from the public engagement included:

- the use of domestic technology to assist those with additional needs
- an increased level of technological adoption than anticipated
- those with a low income and/or within manual trades are impacted the most by digital technology
- digital technology is considered a luxury rather than a necessity and is being reduced due to the cost of living.

The staff responses were evenly split between ward based, desk based and transient / community staff.

The high-level learnings from the staff engagement include:

- 86% staff are excited or neutral about digital technology in the new hospital
- the biggest challenge foreseen was connectivity (internet and inter-system connectivity)
- 7% not confident using the existing technology
- staff were keen to use technology to make their working lives easier (assessing how busy the restaurant was, automatic ordering of meals following surgery, locating of equipment).

The engagement has highlighted opportunities for collaboration which are beginning to be explored. Potential mitigations are being costed with the digital lead. The engagement results will also be used to develop digital personas.

In addition to our public facing engagement, the digital team has undertaken evaluations of our staff's digital capabilities and our technical skills. It is important that understand any gaps we can address, to support all our colleagues in the digital changes we will be going through.

Communications

Public website

Web pages with information about the new hospital are available at <https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx>.

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

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

Newsletter

A newsletter has been launched and more than 500 people have subscribed to it.

Communication with residents

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

Stakeholder briefings

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

2.2.9 Other disclosures

Companies Act disclosures

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

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

Cost allocation

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

Income statement

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

Political donations

The Trust did not make any political donations during 2023-24.

Better payments practice code

The Trust is a signatory to the better payments practice code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust has paid £26k of interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2023-24 (2022-23 £0K).

	2023-24		2022-23	
	Number	£'000	Number	£'000
Total non-NHS trade invoices paid in the year	35,879	177,192	54,600	200,658
Total non-NHS trade invoices paid within target	26,594	152,236	42,929	175,544
Percentage of non-NHS bills paid within target	74.1%	85.9%	78.6%	87.5%
Total NHS trade invoices paid in the year	1,197	11,727	2,158	16,673
Total NHS trade invoices paid within target	642	7,569	1,338	1,565
NHS trade invoices paid within target (%)	53.6%	64.5%	62.0%	81.4%
Total percentage of bills paid within target	73.4%	84.6%	78%	87.0%

Statement regarding the annual report and accounts

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



Dr Ewen Cameron

Chief executive

25 June 2024

2.3 Foundation trust code of governance compliance

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

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

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

2.4 NHS oversight framework

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

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

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

Segmentation

The Trust has been placed in segment 3. This segmentation information is the Trust's position as at 19 June 2024. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/>.

2.5 Statement of accounting officer's responsibilities

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

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

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

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

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

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

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

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



Dr Ewen Cameron

Chief executive

25 June 2024

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2023 to 31 March 2024

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 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

The audit committee provides an independent and objective view of WSFT's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations. It reviews implementation of the board assurance framework to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained. This is supported by 'deep dive' assurance reviews by the assurance committees of the Board as well as the audit committee.

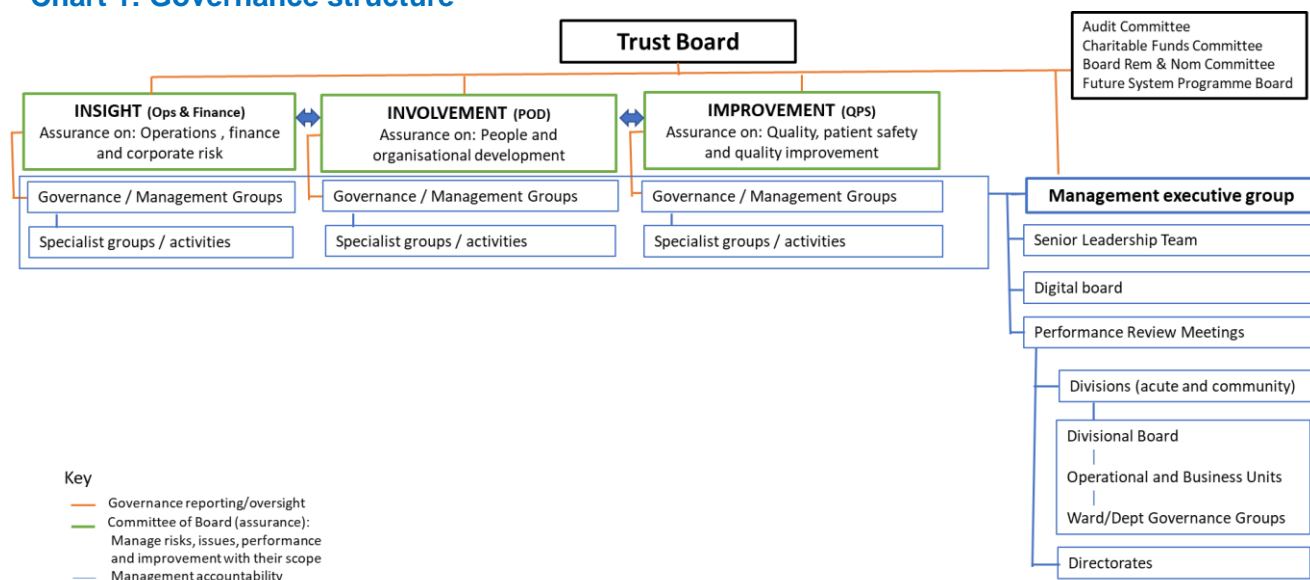
The audit committee independently reviews the effectiveness of risk management systems, ensuring that all significant risks are properly considered and communicated to the Board of directors.

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

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

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

Chart 1: Governance structure



The Council of Governors hold the non-executive directors individually and collectively to account for the performance of the Board of directors.

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

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

The risk and control framework

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

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

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

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

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

- **Care Quality Commission (CQC)** – an overall rating of “requires improvement”
- **performance against national standards** - meeting a number of national targets in 2023-24
- **focus on elective recovery** – the need to reduce the number of people waiting for treatment, usually surgery
- **integration with partners across the health, social care and voluntary sector** – as a key driver in improving the quality and outcomes of care
- development of the **People and Culture Plan** for the Trust is aimed at ensuring there is an overall strategy driven by what our colleagues tell us – to support our people, we need to know how they feel about their working lives
- **National Hip Fracture Database (NHFD)** has rated WSFT as the top hospital in England and Wales for the care of patients with a hip fracture in 2023
- **Sentinel Stroke National Audit Programme (SSNAP)** - a major healthcare quality improvement programme for stroke care. For the last quarter reported (at the end of 2023), our stroke team has maintained its high score of 90 as an acute admitting stroke unit
- **Getting It Right First Time (GIRFT)** general surgery High Volume, Low Complexity (HVLC) review was commended as the best example of system working in general surgery reviewed so far
- positive results from the **2023 NHS Maternity Services Survey** highlighting an upward trend of improvement in the quality and safety of the maternity care provided by WSFT
- the **Patient Safety Incident Response Plan (PSIRP)** for 2023-24 was launched, to help create a safer culture and drive improvement, and is a requirement under the national Patient Safety Incident Response Framework (PSIRF)
- **pulmonary rehabilitation (PR) service received national accreditation** – the service is part of our community and integrated therapies division
- introduction of the **unscheduled care coordination hub (UCCH)** has been a tool that symbolises the benefits of system working and delivering the right care, at the right time, in the right place

- the **Trust's vaccination team** has continued its dedicated work to protect our staff, system partners and the community of Suffolk from seasonal viruses
- **excellent reputation for teaching** – both undergraduate and graduate. We are a learning organisation and our training and education team support staff with a broad range of courses and training
- **expanded our Freedom to Speak Up (FTSU) network** - introduced wellbeing champions to reflect our diverse workforce, and relaunched our peer-led staff networks
- **our highly-trained and motivated workforce** - investing in, celebrating and looking after the thousands of people who devote their working lives to the NHS and our Trust
- **building of a new hospital** – including exploratory and preparatory works ahead of the construction phase
- construction of the new **Newmarket Community Diagnostic Centre (CDC)** at the town's community hospital is progressing. It is on track to see its first patients before Christmas 2024.

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

Many challenges remain, including during 2023-24, extensive periods of industrial action. We recognise these disputes are between the unions and the Government and we support the legal right to strike. The willingness of our colleagues to help us plan and work flexibly around these actions has shown once again their commitment to each other and to our patients, and their dedication to serve the people of West Suffolk.

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

- **staff engagement and raising concerns** – previously this has been identified as a significant internal control issue for reporting purposes. The Board's review of this including relevant evidence has not identified this as a significant internal control issue for 2023-24. The evidence includes:
 - improvement in responses given in our staff survey, and relative position in the region (second against comparator trusts)
 - the successful delivery of the Trust's organisational development plan following the West Suffolk Review, with a substantial assurance rating by our internal auditors
 - the development and delivery of a comprehensive People and Culture plan during the year
 - the findings as outlined in the recent well-led review report which noted example of progress and noted: 'staff speaking positively about the overall culture and feel of the Trust' and 'evidence of significant investment and Board focus in this area which has had a positive impact'.

We will continue to focus on various aspects of improvement in our culture, including work with the FTSU agenda.

The following are considered in detail within the significant internal control section of the report:

- **building structure**
- **delivering patient access**
- **financial sustainability.**

Risks to our strategic objectives are regularly reviewed by the Board as part of the board assurance framework (BAF). The BAF has been subject to development by the Board during 2023-24 and is summarised below.

Board assurance framework summary

Description of risk	Potential impacts being mitigated by controls and future plans
Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (including developing our current and future staff)	<ul style="list-style-type: none"> • staff do not have the skills to provide optimum treatment to our patients • the needs of patients are not met when skills and knowledge are lost • vacancies and/or reliance on temporary workforce; pressure on existing teams
Fail to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities	<ul style="list-style-type: none"> • patient harm due to delays in diagnosis and treatment • inability to meet current and future population health and care needs • regulatory intervention as a result of not meeting NHS performance standards • people being treated in an inappropriate setting and an unsustainable future model • unsustainable workforce to provide capacity
Fail to work effectively with our partners to ensure the greatest possible contribution to preventing ill health, increasing wellbeing and reducing health inequalities	<ul style="list-style-type: none"> • failure to meet population health and care demand • services remain responsive, rather than proactive (unable to adequately focus on prevention) • ill health outcomes will continue to rise and system will become an outlier • inefficient use of resources • failure to deliver system quality gains through collaboration
Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities	<ul style="list-style-type: none"> • less effective and lower quality service delivered in a way that is more expensive, not reflecting developments/innovation • increased likelihood of digital systems failure, greater risk of cyber-attack and data loss, resulting in inability to access clinical information in a timely way • data quality is unreliable, unstructured and cannot be used for reporting and clinical decision support
Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future	<ul style="list-style-type: none"> • building environment not suitable/safe for patient care leading to harm incident(s) – subsequent reputation damage. Unknown financial impact of reputational consequences • risk of improvement notices if fail to improve condition of building(s) • impact of proceeding at risk on cash position • service withdrawal due to inability to achieve/maintain accreditation/licencing • failure to effectively mitigate the reduction in risk of partial building collapse
Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values	<ul style="list-style-type: none"> • overspend • budgets inaccurate/unachievable • negative patient/stakeholder experience • inability to deliver strategic plans • continued deterioration of estates

Description of risk	Potential impacts being mitigated by controls and future plans
Fail to ensure the Trust has the appropriate governance structures, principles and behaviours to help us safely deliver the best quality and safest care for our local population (our vision) and ambitions (for patients, staff and the future) in the right way	<ul style="list-style-type: none"> • patient harm - physical, psychological, including patient/carer experience • reputation damage - regulatory intervention • staff morale impact - health and wellbeing • staff recruitment/retention
Fail to effectively engage and communicate with our patients and the public, reducing inequality and responding to the needs of our communities	<ul style="list-style-type: none"> • failure to comply with statutory duties • legal challenge and reputational damage • patient services do not reflect the views of the public and patients and therefore not designed around the needs of our community • services will not reflect the needs of our underrepresented groups • planned service developments are delayed
Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff	<ul style="list-style-type: none"> • safe staffing and well-led – quality and safety • reputation management • adverse employee relations and staff motivation • CQC regulatory action • withdrawal of Royal College, and/or General Medical Council, and/or Health Education England recognition • reduction in staff engagement and morale, impacting on patient care • higher levels of sickness absence • inability to recruit/retain staff

In considering the risks and challenges it faces the Board has appointed a new director of strategy and transformation and is working to fill current and future NED vacancies. These appointments provide an opportunity for the Trust to drive its value-based recruitment. Following a full and competitive recruitment process the Council of Governors appointed Jude Chin as chair of West Suffolk NHS Foundation Trust. A term he will serve until June 2026.

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

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

- activities of the involvement committee of the board
- integrated quality and performance report (IQPR) and workforce report - both reports are received at each public Board meeting. These reports detail a range of metrics including patient outcomes, patient experience and staffing performance indicators
- nurse staffing monthly report to the Board which details the nurse staffing position and the Trust's future plans for nurse staffing
- Board reporting is underpinned by monthly divisional workforce reports which detail a range of performance indicators including sickness absence, turnover, maternity leave, training and average absence

- assessment of staff experience using the friends and family test (FFT), national staff survey and exit interviews
- we have also established networks for staff including BAME, disabilities and LGBT+
- Freedom to Speak Up Guardian and Guardian of Safe Working reporting to the Board
- e-rostering and e-job planning system for medical staff
- the Trust's clinical workforce strategy group oversees the development of new roles to support sustainability within the labour market.

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

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in NHS guidance.

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

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

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

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

The BAF was reviewed and updated during 2023-24 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for cause and effect. The Board also reviewed its risk appetite against each of the identified BAF risks. The Board and its assurance committees analyse the key controls and assurances to ensure that the Trust can manage its risks to a reasonable level and that the Board of directors is adequately informed of the effectiveness of control measures and that, where appropriate corrective action is being taken to reduce risk levels with are above tolerance. This review has identified gaps in control or assurance as set out in the significant internal control section of the annual governance statement. The BAF is subject to independent review by internal audit.

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

- effectiveness of governance structures – subject to annual review and recommendations for improvement monitored through an agreed action plan
- responsibilities of directors – directors' objectives and performance are regularly monitored by the remuneration committee
- responsibilities of subcommittees - are considered as part of the annual governance review and the quality and risk committee and audit committee provide an annual report to the Board on their activities and performance

- reporting lines and accountabilities between the Board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the Board and executive team
- submission of timely and accurate information to assess risks to compliance with the Trust's licence
- degree and rigour of oversight the Board has over the Trust's performance – the Board continually reviews and develops its reporting arrangements to the Board. The monthly quality and performance report for the Board supports an open reporting culture and includes the results from the Friends and Family Test. The range of indicators provides early warning of deterioration in performance and potential negative impact on quality. The finance and workforce report has been strengthened during the year including divisional reporting and performance against cost improvement programmes.

The Trust places a high priority on the quality of its clinical outcomes, patient safety and patient experience and strives to deliver the principles outlined in NHSE's well-led framework and its underpinning quality statements:

1. Shared direction and culture
2. Capable, compassionate, and inclusive leaders
3. Freedom to speak up
4. Workforce equality, diversity and inclusion
5. Governance, management and sustainability
6. Partnerships and communities
7. Learning, improvement and innovation
8. Environmental sustainability.

In line with good governance practice, during 2023-24 the Board commissioned ConsultOne (the consultancy arm of AuditOne) to undertake a well-led developmental review of leadership and governance at the Trust. The review took place between December 2023 and March 2024, to inform further development work to support continuous improvement of our governance arrangements.

The review process included documentary assessment, interviews with Board members, members of staff, governors and external stakeholders as well as meeting observations for the Board and its committees, Council of Governors and operational management meetings.

The final report was issued in May 2024 and highlights well-led strengths and areas of further focus by the WSFT Board. An improvement plan to address the findings of the report is being prepared which will be structured around the recent CQC well led guidance.

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

The key elements of the Trust's operational and financial plans have been monitored by the Financial Accountability Committee and the Insight Committee has sought assurance on behalf of the Board of Directors.

The priorities set out in the Trust's Internal Audit Plan are based on analysis of corporate objectives, risk profile and assurance framework as well as other factors affecting the Trust in the year ahead, including changes within the sector. The findings of internal audit reports are reported to the Audit Committee. Non-financial audits relating to quality are considered by the improvement and involvement committees.

The process to ensure that resources are used economically, efficiently and effectively across clinical services include divisional performance review meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

Information governance

WSFT's data security and protection assessment report overall score for 2022-23 was 'Standards Not Met' at publication in June 2023. An improvement plan was submitted to NHS Digital and this was accepted. The 2022-23 improvement plan was completed and the Trust's status was amended to 'Standards Met' in February 2024.

The final assessment for 2023-24 had not been submitted at time of reporting.

The Trust received one complaint via the Information Commissioner's Office (ICO) in 2023-24. This was closed with no further action. The Trust did not report any data breaches to the ICO in 2023-24.

Data quality and governance

The assessment of performance data, including quality metrics, is an integral part of the Trust's performance management system. The Trust produces a monthly Integrated Quality Performance Report which includes operational, quality, workforce and financial data. In addition to an ongoing programme of internal review and audit of data quality, data quality is subject to periodic audit by the Trust's internal auditors.

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 and its assurance committees as part of the performance monitoring arrangements.

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

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

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

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been

advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, the board's assurance committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

In accordance with the public sector internal audit standards updated in 2017, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the Board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Internal audit reported eleven reports from the 2023-24 plan for which an assurance opinion was provided; the 'opinion levels' are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	0
Substantial assurance - controls are suitably designed, consistently applied and operating effectively	0
Reasonable assurance - identified issues that need to be addressed	9
Partial assurance - action is needed	2
No assurance - urgent action is needed	0

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

- **Community waiting list – therapy** – partial assurance
- **Discharge planning and management** – partial assurance

The internal audit review for the data security and protection toolkit (DSPT) covering 2022-23 was completed during 2023-24. The review was based on the NHS Digital guidelines and scoring mechanisms, for which one high, nine medium and seven low priority actions were agreed with management and resulted in a moderate assurance opinion. An improvement plan was submitted to NHS Digital and this was accepted. The 2022-23 improvement plan was completed and the Trust's status was amended to 'Standards Met' in February 2024.

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

For the 12 months ending 31 March 2024, the head of internal audit's opinion for WSFT is that: "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

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

In preparing this annual governance statement, as required under NHS foundation trust conditions, all relevant internal and external assurances 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:

- **Building structure**

The building structural challenges we face at West Suffolk Hospital are well known and we have long documented that, according to structural engineer experts, our building's 'shelf life' is unlikely to extend beyond 2030.

The Trust has faced estate challenges regarding its roof for a number of years, and has put approved mitigations in place, such as reducing the weight on it. These mitigations are recommended by structural engineers, well-managed, and reported to our regulators as part of our planned estates works.

The need for a new hospital has been nationally acknowledged and WSFT, and the rest of the West Suffolk health system, were delighted that the Trust was named as one of 40 to benefit from the Government's New Hospital Programme. However, whilst this news is very much welcome, any new facility will not be open for several years and we have a duty to ensure that the existing hospital is appropriately maintained and we are able to continue to provide high quality health services for our community.

In 2019 an additional, specific structural risk was identified about reinforced autoclaved aerated concrete (RAAC) planks, which were used in the original build of West Suffolk Hospital and the front residences in the 1970s.

The alert received was from the Standing Committee on Structural Safety (SCOSS), which reported one shear RAAC plank failure in a non-NHS site built of similar material and construction. The alert recommended that inspection work be carried out on buildings of RAAC construction, giving guidance on how to further assess the condition and structural adequacy of the planks.

Our estates teams have been proactive and robust in tackling this issue.

Since receiving the alert, they have mapped every plank across the organisation, and implemented an assessment programme using sophisticated radar equipment and other approved tests to check all planks for signs of stress. The teams are carrying out remedial repairs across the estate as part of this, and work did not stop during the pandemic.

The Trust has engaged experienced structural engineers and experts to support the inspection work. All planks will be continually assessed in a rolling programme of routine estates work until we move to a new hospital site. In addition, proactive programmes of precautionary maintenance work are well under way around the hospital to further ensure the safety of our patients, visitors, and staff.

We are not complacent, this has and will continue to have our absolute attention and focus. Staff, patient and visitor safety matters to us above all else.

This issue has not been caused by a failing of the Trust, which has managed its estates repairs well within the means available, but by the ageing of a product in our roof that cannot be replaced. We want to be transparent about our challenges and to reassure our patients, staff and community.

The programme of works to inspect the building structure and implement required mitigating action continues and we have received additional funding to support the programme during 2023-24.

The Government has committed to prioritising the replacement of hospitals containing RAAC, including West Suffolk Hospital, taking us one step closer to making the replacement of our Hardwick Lane Hospital a reality. The next stage of the project is the completion of the second of three business cases, known as the outline business case. The project team will also continue to work closely with the New Hospital Programme team to ensure designs and activities take full advantage of the centralised programmatic approach.

- **Delivering patient access**

Each year, the NHS publishes a set of operational priorities. For 2024-25 there are 32 objectives, most of which are relevant to WSFT as a provider of acute, community and primary care services.

Many objectives represent a continuation of those from 2023-24, however not all were achieved in full last year. Therefore additional activity and/or performance improvement will be required to achieve them. The Trust has committed to meet the performance expectations by the required timescales. While our absolute elective activity targets are not forecast to achieve the required 108.09% of 2019-20 levels this is mitigated when the value-weighted activity calculation is applied, as some units of activity (operations or procedures) have a higher value than others.

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

There has been significant progress in reducing waiting times for patients during 2023-24 including the elimination of 104-week waits. Following positive progress throughout the year, the number of 78-week and 65-week waits were higher than revised trajectories at the end of March 2024, due to industrial action during February.

The 2023-24 planning guidance requirement to eliminate elective waits of 65 weeks or more has been extended by six months to be delivered by the end of September 2024. For WSFT, this will require the end of March backlog of 407 patients to be cleared, as well as patients whose waits are not yet at 65 weeks but will be by the end of September deadline. This will require additional activity within the sub-specialty of urogynaecology.

There is a new target, that each ICS must increase the proportion of outpatient attendances that are either a first attendance, or a 'clock stopping' follow-up attendance including a procedure. This means more patients will receive the treatment they need sooner. It is anticipated that this can be achieved in a number of ways, including changing the mix of outpatient appointments and ensuring all activity is correctly coded.

The two-year objective of 95% of diagnostic tests delivered within six weeks by March 2025 is reiterated in this year's planning guidance. Given that all diagnostic modalities at WSFT committed to the delivery of this last year and there have been no material impacts to demand or capacity, the Trust is recommitting to this objective for 2024-25. The Community Diagnostic Centre (CDC) at Newmarket, expected to open by Christmas 2024, will provide a significant step change in some modalities, but further activity increases from existing recovery plans will also be required, particularly in endoscopy where there will be no additional CDC capacity.

This year saw strong recovery of cancer performance, building solid foundations to support delivery of the 2024-25 objectives. The Trust has committed to 77% of patients receiving a diagnosis of all-clear within 28 days of referral (the Faster Diagnosis Standard); and 70% of cancer patients being treated within 62 days of referral.

Services and pathways will need to build on improvements and transformation work already completed, particularly to respond to increases in demand across the high-volume pathways in suspected breast, lower gastrointestinal tract and skin cancers.

Urgent and emergency care

Having reintroduced the 4-hour standard for the emergency department (ED) in May 2023, WSFT has demonstrated variable performance with significant progress in March, ending the year with 74% against the standard of 76%.

The headline metric for urgent and emergency care (UEC) will continue to be the 4-hour standard, which will increase from 76% to 78% by March 2025. Ambulance handover times will need to be maintained below 30 minutes and the number of patients waiting 12 hours or more in the Emergency Department (ED) will need to be reduced from current levels.

Key to delivery and further improvement will be consolidating and continuing workstreams from 2023-24 plans, including those funded by the UEC capacity and discharge fund streams, alongside new developments such as the six-month trial of a minor emergency care unit. Within the department, lessons learned from the additional senior operational and clinical leadership support in March 2024 will be captured and embedded within an evolved recovery plan. This additional support may need to be deployed again should performance significantly deviate from trajectory.

- **Financial control and sustainability**

The Trust recorded a deficit of £6.3m in 2023-24, after benefitting from non-recurring support of £15m. As a result, the Trust faces a significant underlying deficit in 2024-25 and has a challenging cost improvement programme (CIP) of £16.5m (4%) to meet its planned deficit of £15.2m in 2024-25.

Furthermore, the Trust aims to break even in 2026-27 and therefore requires recurring CIPs of £38m over these three years in order to achieve that.

To address our underlying deficit the Trust established a financial resource group in August 2023, chaired by the chief executive officer. This group meets fortnightly and focuses on our CIP and underlying run rate. Its role is to ensure cost savings are delivered at pace with Trust ownership; and that the savings are recurring through permanent culture change Our Workforce Resource Group which focuses on staffing efficiencies reports to FRG.

The SNEE ICB commissioned PA Consulting (PAC) to review the Trust's financial position and their report has highlighted opportunities for efficiencies. PAC used benchmarking to identify corporate opportunities and highlighted where controls could be improved. This has helped to shape our plans to break even in 2026-27.

We have also reviewed executive director responsibilities to ensure capability and capacity is applied to strategic plans as part of the CIP.

Our financial governance has been strengthened through the financial accountability committee (FAC) which meets each month. This includes a broad agenda of finance related matters, with a focus on ensuring budgets are set appropriately and CIP is clearly allocated. Financial performance is monitored against plan and reported to insight committee of the Board. This committee provides Board-level challenge to the financial position and assurance to the Board of directors.

I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of processes of internal control and assurance. This includes the effective tracking of action to mitigate significant control issues through the board assurance framework.

A handwritten signature in blue ink, appearing to read 'Ewen Cameron', with a long horizontal flourish extending to the right.

Dr Ewen Cameron
Chief executive
25 June 2024

2.7 Remuneration report

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

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

The following parts of the remuneration report are subject to audit:

- single total figure table of remuneration for each senior manager
- pension entitlement table and other pension disclosures for each senior manager
- fair pay disclosures
- staff report: exit packages, analysis of staff numbers and analysis of staff costs.

Annual statement on remuneration

Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses.

Senior managers' remuneration policy

The guiding principles for salary awards are set out in detail in the Trust's executive directors' remuneration policy approved by the remuneration committee. The policy confirms that the Trust's aim is to maintain executive director salaries at an appropriate level in relation to their peers, taking into account the expectation of high levels of personal and collective performance which will allow the Trust to achieve the highest level of quality and financial performance.

Future policy table

Pay component	How the Trust operates this component	Maximum limit	Performance measures
Base salary	When setting remuneration for senior managers the Remuneration Committee reviews: <ul style="list-style-type: none">• role, responsibilities and accountabilities• assessment of performance against agreed objectives• skills, experience and performance• Trust performance• national and local pay awards• Local and national employment market conditions• NHS advice and Treasury guidance• benchmarking across the NHS.	£150,000 threshold for Treasury disclosure. There is no maximum prescribed limit.	Not applicable
Taxable benefits	Senior managers' benefits include: <ul style="list-style-type: none">• a car lease scheme• pension-related benefits.	There is no maximum prescribed limit.	Not applicable

	Non-executive directors do not receive benefits.		
Pension	<p>The Trust operates the standard NHS pension scheme.</p> <p>Senior staff may opt out of the pension scheme and receive an amount equal to the employer contributions (that would be payable if they were in a scheme) to be paid to themselves and instead invest in a pension arrangement of their choice.</p> <p>This does not increase the overall cost to the Foundation Trust.</p>	In line with the NHS pension scheme.	Not applicable
Bonus	The Trust does not have any bonus arrangements in place for very senior managers.		

There have been no additions or changes to the components of the remuneration package during 2023/24.

Remuneration committee

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

- advise the Board about appropriate remuneration and terms of service for the chief executive, other executive directors and other senior employees including:
 - all aspects of salary (including any performance-related elements/bonuses)
 - provisions for other benefits, including pensions and cars
 - arrangements for termination of employment and other contractual terms
- make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff
- scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate, advise on and oversee appropriate contractual arrangements for such staff
- monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including:
 - establishing the objectives of the chief executive and review the performance of the chief executive against these objectives which support the Trust's priorities
 - scrutinising the objectives of the executive directors (to be established by the chief executive and to support the Trust's priorities) and review performance reports on the executive directors prepared by the chief executive
- scrutinise the recommendations of the clinical excellence awards committee
- review the terms of reference of the committee every two years
- report the frequency of meetings and the members of the remuneration committee in the Trust's annual report
- the committee shall report in writing to the Board the basis for its recommendations
- consider the Trust's equality, diversity and inclusion policy in all decisions made, the objectives of which are linked to the Trust's overall strategy. Further detail regarding equality and diversity inclusion is provided within section 2.8.8 (staff report).

The committee comprises the Trust chair and non-executive directors of the Board. The committee is chaired by a non-executive director. The chief executive, executive director of workforce and communications and trust secretary may be present to advise but not for any discussions concerning their personal remuneration at the discretion of the remuneration committee's chair.

A quorum will consist of the committee chair (or nominated representative) and at least two non-executive directors. A nominated representative for the chair must be a non-executive director.

The committee acts with delegated authority from the Board and will usually meet at least annually. Minutes are taken and a report submitted to the Board showing the basis for the recommendations. Three meetings of the remuneration committee were held during 2023-24.

Attendance at remuneration committee meetings

Name	Title	Attendance (out of 3)
Jude Chin	Trust Chair (remuneration committee chair)	3
Michael Parsons	Non-executive director	3
Louisa Pepper	Non-executive director	3
Tracy Dowling ⁽¹⁾	Non-executive director	2
Antoinette Jackson	Non-executive director	3
Geraldine O'Sullivan	Non-executive director	3
Krishna Yergol	Non-executive director	2
John Petter	Non-executive director	3

Meeting dates: 19 July 2023, 2nd October 2023, 17 January 2024

⁽¹⁾ Tracy Dowling went on a secondment from 17 October 2023

Senior managers' (executive directors') pay is annually reviewed by the remuneration committee. The committee is presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS market in the context of pay awards to other staff groups. Decisions to increase salaries are based on this information, internal equity, affordability, whether there has been a significant change in a director's portfolio and thus responsibility. Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable, including any senior manager paid more than £150,000. In addition, each director can receive the NHS cost of living pay rise which is based on the national NHS pay award. In recent years the Department of Health and Social Care has advised the chair on the expected level. The arrangement for managing the remuneration policy for senior managers was strengthened from 2018/19 to include engagement with staff and public governors.

The Trust does not have a performance-related pay scheme. The committee, however, has the delegated authority to pay one-off discretionary payments in exceptional circumstances. The chief executive presents an annual report on executive directors' performance (in the case of the chief executive this is presented by the chair) based on the outcome of their annual appraisal.

The senior managers' salary does not include separate components and there are no performance measures that apply. Clinical elements are included in the salary of the Medical Director as part of the work undertaken in their medical role.

Service contracts obligations

The Trust's executive directors hold substantive service contracts. Notice periods apply based on the early termination of their contract. The notice periods are as follows:

- chief executive – six months
- executive directors – three months.

The non-executive directors hold a term for 3 years. Further details can be found in section 2.2 (directors' report).

Policy on payment for loss of office

Approval for any non-contractual severance payments should be obtained from the remuneration committee and NHS Improvement following submission of a business case. In respect of individuals earning over £100,000, any severance payment should include a provision requiring the repayment of the severance payment where the individual returns to work for the NHS in England within 12 months and/or before the expiry date of the period for which they have been compensated (as measured in equivalent months/part-months of salary). In such circumstances the employee would be required to repay any unexpired element of their compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary.

Annual report on remuneration

In the financial year the directors' costs increased to £1,178k from £1,092k. There were no exit packages paid to Board members in the 2023/24 financial year or the comparative year.

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

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Both directors and governors are able to reclaim expenses necessarily incurred during the course of their duties. Details of these are shown below. The numbers include individuals who have acted in their capacity as director or governor for any part of the financial year.

	2023/24		2022/23	
	Directors	Governors	Directors	Governors
Total number in office during the year	14	26	18	28
Total number receiving expenses	12	11	8	5
Aggregate total of expenses paid during the year (£'00)	154	14	112	6

Fair pay disclosure

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2023/24 was £215k - £220k (2022/23 £210k - £215k), an increase of 2.35% (2022/23 7.59%) from the mid-point of the bands. This increase in remuneration reflects a full year in post for the Trust's new Chief Executive and the previous highest paid director spending part of the prior year in their substantive post as Director of Resources. The increase is partially suppressed due to the previous highest paid director

opting out of the pension scheme and consequently receiving increased remuneration classified as salary, whereas the current year highest paid director continues to receive benefits in the form of pension contributions.

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

For employees of the Trust as a whole, the range of remuneration in 2023/24 was from £19,264 to £288,771 (2022/23 £13,859 to £297,364). The decrease in the high end of the range between periods is a result of the number of enhanced medical sessions completed by the highest paid consultant in the prior year, that were not quite matched in the current year. The increase in the low end of the range is because all Non-Executive Directors claimed taxable expenses in the current year such that their reportable pay exceeded that of the lowest banded employees, whereas in the prior year the lowest pay was the annualised remuneration for a non-executive director who commenced in post February 2023 and did not incur any taxable expenses before year-end. The percentage change in average employee remuneration (based on total for all employees on an annualised full time equivalent basis divided by full time equivalent number of employees) between years is 3.52% (2022/23 10.2%). The 2022/23 increase in average employee remuneration included enhanced non-consolidated pay awards but this was not repeated in 2023/24. Twenty-two employees received remuneration exceeding that of the highest-paid director in 2023/24 (2022/23 ten employees), an increase that reflects a higher number of medical consultants at the top pay scale completing additional sessions.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2023-24	25th Percentile	Median	75th Percentile
Total pay and benefits exc. pension benefits	25,527	34,688	46,002
Salary component of pay	22,816	31,519	43,742
Pay and benefits excluding pension:pay ratio for highest paid director	8.5	6.3	4.7

2022-23	25th Percentile	Median	75th Percentile
Total pay and benefits exc. pension benefits	25,332	34,034	45,441
Salary component of pay	25,332	34,034	45,441
Pay and benefits excluding pension:pay ratio for highest paid director	8.4	6.2	4.7

The mid-point of the highest paid director's salary and allowances band was 6.3 times (2022/23 6.2 times) the median remuneration of the workforce, which was £34,688 (2022/23 £34,034). This is calculated based on all staff employed, including agency staff covering vacancies, as at 31 March 2024. The ratio increased marginally because the mid-point of the highest paid director's remuneration band, per the single total figure table, increased at a lower rate than the median remuneration of the workforce. The primary factor in the median pay increase, and also to the increase in average employee remuneration, is increases awarded to the workforce generally.

Similarly consistent between 2022/23 and 2023/24 are the ratios between the mid-point of the highest paid director's salary and allowances band and the remuneration of the employee at the 25th and 75th percentiles – respectively 8.5 (2022/23 8.4) and 4.7 (2022/23 4.7).

Table A – Single total figure

Name and title	Year to 31 March 2024				Year to 31 March 2023			
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	All pension- related benefits (bands of £2500)	Total (bands of £5000)	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	All pension- related benefits (bands of £2500)	Total (bands of £5000)
	£000	£00	£000	£000	£000	£00	£000	£000
Mr C Black – Executive director of resources	185 - 190	13	-	185 - 190	210 - 215	14	-	210 - 215
Dr E Cameron - Chief executive	215 - 220	-	360 - 362.5	575 - 580	20 - 25	-	100 - 102.5	120 - 125
Mr J Chin - Chair	50 - 55	36	-	55 - 60	50 - 55	45	-	55 - 60
Mrs N Cottington - Executive chief operating officer	125 - 130	8	-	130 - 135	125 - 130	5	117.5 - 120	245 - 250
Dr R Davies – Non-executive director (Note 3)	-	-	-	-	10 - 15	-	-	10 - 15
Mrs T Dowling – Non-executive director (Note 2)	5 - 10	16	-	10 - 15	5 - 10	4	-	5 - 10
Ms A Jackson – Non-executive director	10 - 15	5	-	15 - 20	5 - 10	-	-	5 - 10
Mr C Lawrence - Non-executive director (Note 5)	-	-	-	-	5 - 10	-	-	5 - 10
Mr N Macdonald - Deputy director of finance (Note 4)	-	-	-	-	125 - 130	18	-	130 - 135
Ms H McCallion - Non-executive director (Note 6)	-	-	-	-	0 - 5	-	-	0 - 5
Dr P Molyneux - Executive medical director	215 - 220	-	-	215 - 220	205 - 210	-	97.5 - 100	305 - 310
Dr G O'Sullivan – Non-executive director	10 - 15	7	-	15 - 20	5 - 10	-	-	5 - 10
Mr J Over – Executive director workforce & communications	125 - 130	12	-	130 - 135	120 - 125	12	37.5 - 40	160 - 165
Mr M Parsons – Non-executive director (Note 1)	10 - 15	3	-	10 - 15	-	-	-	-
Mrs L Pepper – Non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr R Petter – Non-executive director	15 - 20	15	-	15 - 20	-	-	-	-
Mrs S Wilkinson - Executive chief nurse	130 - 135	-	-	130 - 135	125 - 130	-	52.5 - 55	180 - 185
Mr K Yergol – Non-executive director	10 - 15	10	-	15 - 20	5 - 10	6	-	5 - 10

No additional performance pay and bonuses were paid to directors in 2023-24 or 2023-23.

Table B – Pension benefits to 31 March 2024

Name	Real increase / decrease in pension (Bands of £2,500)	Real increase / decrease in lump sum (Bands of £2,500)	Total accrued pension (Bands of £5,000)	Total lump sum (Bands of £5,000)	CETV 1/04/2023	Real increase in CETV	CETV 31/03/2024
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr C Black (Note 7)	0	0	0	0	0	0	0
Dr E Cameron	12.5 - 15	90 - 92.5	70 - 75	195 - 200	949	607	1,681
Mrs N Cottingham	0	27.5 - 30	40 - 45	105 - 110	642	143	868
Dr P Molyneux	0	42.5 - 45	90 - 95	250 - 255	1,738	298	2,240
Mr J Over	0	27.5 - 30	35 - 40	95 - 100	556	104	734
Mrs S Wilkinson	0	0	55 - 60	160 - 165	1,278	75	1,500

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Notes

1. Mr M Parsons was appointed as a NED from May 2023
2. Mrs T Dowling was a NED to November 2023.
3. Mr R Davies was a NED to February 2023, included in table for comparative only.
4. Mr N Macdonald was an Executive Director to February 2023, included in table for comparative only.
5. Mr C Lawrence was a NED to October 2022, included in table for comparative only.
6. Ms H McCallion was a NED until March 2023, included in table for comparative only.
7. Mr C Black chose not to be covered by the pension arrangements during the reporting year.



Dr Ewen Cameron

Chief executive
25 June 2024

2.8 Staff report

2.8.1 Our staff

The Trust is one of the largest employers in west Suffolk, employing 5,500 staff in April 2024. It firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2023-24 with the following activities:

- the Trust's results from the 2023 NHS Staff Survey were, in the main, an improvement on the previous years' results and slightly above the national average scores
- our Freedom to Speak Up Guardian, supported by Freedom to Speak Up champions across the organisation, continue to support an open and inclusive culture
- staff governors also continue to support staff to discuss challenges and achievements and report on these
- as part of the Trust's health and wellbeing programme we continue to focus on both emotional and physical health and wellbeing. We provide a clinical psychologist-led staff support psychology service (renamed the staff support and wellbeing service) and offer a wide range of benefits to support staff, including a staff physiotherapist
- all staff continue to have access to free membership of Abbeycroft Leisure which includes access to physical facilities and virtual classes
- we continue to invest in a full-time staff side lead role
- we continue to develop our partnership working through the following groups:
 - Trust Council
 - Trust negotiating committee (medical and dental)
 - People and Culture leadership group
 - Looking after our people (health and wellbeing steering group)
 - Belonging in the NHS (equality, diversity, and inclusion steering group)
 - Growing for the future (recruitment and retention working group)
 - Workforce policy steering group
 - New ways of working steering group.

2.8.2 Staff costs

Staff costs

			2023-34	2022-23
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	210,857	425	211,282	200,360
Social security costs	23,764	123	23,887	22,017
Apprenticeship levy	1,032	-	1,032	981
Employer's contributions to NHS pension scheme	35,817	-	35,817	32,356
Pension cost - other	95	-	95	86
Other employment benefits	-	157	157	-
Temporary staff	-	7,019	7,019	6,253
Total staff costs	271,565	7,724	279,289	262,053
Of which				
Costs capitalised as part of assets	2,587	-	2,587	2,382

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

Average number of employees (WTE basis)

	Permanent Number	Other Number	2023-24 Total Number	2022-23 Total Number
Medical and dental	552	65	617	569
Administration and estates	1,066	55	1,122	1,002
Healthcare assistants and other support staff	862	139	1,000	944
Nursing, midwifery and health visiting staff	1,311	106	1,417	1,307
Scientific, therapeutic and technical staff	847	17	864	809
Total average numbers	4,638	382	5,020	4,631

Of which:

Number of employees (WTE) engaged on capital projects

37	-	37	39
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2.8.4 Reporting of compensation schemes - exit packages 2023-24

There were two compensation schemes/exit packages recorded in 2023-24 (none in 2022-23). Both were compulsory redundancies with values of £13,000 and £33,000.

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

	Male	Female	Total
Executive directors (including CEO)	4	2	6
Non-executive directors (including chair)	4	3	7
Other senior managers (band 8d and above)	12	10	22
Employees	1,091	4,335	5,426
Total	1,111	4,350	5,461

Source: Electronic Staff Record (as at 1/4/2024)

2.8.6 Sickness absence data

The Trust has systems and processes in place to manage both long- and short-term sickness absence, in accordance with best practice and legislative requirements. The performance for the year is available via <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>.

2.8.7 Trade union facility time information

Number of employees who were trade union officials	Whole time equivalent
41	35.99
Percentage of time spent on facility time	Number of employees
0%	25
1%-50%	15
51% - 99%	0
100%	1
Total cost of facility time	Costs
Total pay bill	£271,238,000
Percentage of pay bill spent on facility time	0.03%
Time spent on trade union activities as percentage of total facilities time	Percentage
236	7.8%

2.8.8 Equality and diversity

The Trust is committed to the provision of high quality, safe care for all members of the communities it serves and to the development of a culture of inclusion where all people are valued and respected for their individual differences. This is evidenced by our strategy: First for patients, staff and the future.

This means we will embrace all people irrespective of, for example, race, religion or belief, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability. We will give equal access and opportunities and remove discrimination and intolerance. We will do this both as an employer and as a service provider.

In 2023 we created a staff focused Inclusion Workplan, which draws from an in-depth analysis of emergent data from the national NHS staff survey, the NHS Workforce Race Equality Standard (WRES) indicators, the NHS Workforce Disability Equality Standards (WDES), our gender pay gap report, our Freedom to Speak Up themes, and a range of listening exercises undertaken across the Trust. It also incorporates actions as defined by the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, the Unison Anti-racism Charter and the Inclusive Leadership Pledge. Through this we have been able to integrate a range of strategic and operational actions from multiple sources into one cohesive plan, with seven key workstreams:

1. Board responsibilities
2. Recruitment and talent management
3. Data analysis and reporting
4. Governance, policies, strategies and guidance
5. Learning and development
6. People processes
7. Additional actions.

Workstream leads are taking forward actions within each theme, with progress tracked and captured and on-going evaluation and review taking place.

The Equality Delivery System (EDS) was submitted in full for the first time in February 2024, with an overall rating of 19, which is at the higher end of the 'developing' score. Actions for the improvement of commissioned or provided services, workforce health and wellbeing, and inclusive leadership are all being taken forward. This can be accessed on our website here: [NHS Equality Delivery System \(EDS\) \(wsh.nhs.uk\)](https://wsh.nhs.uk/equality-delivery-system)

Governance is provided for this agenda through the looking after our people group, which reports into the people and culture leadership group, providing assurance to the involvement committee as a sub-committee of the Board. Consideration of a separate patient-facing EDI group is being considered given the breadth of agendas and differing legislative requirements.

Progress is monitored and a six-monthly update on progress with the inclusion workplan is received by the involvement committee.

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

Employees and public members protected characteristics

	Staff in post				Public members			
	2023-24	2022-23	2021-22	2020-21	2023-24	2022-23	2021-22	2020-21
Age								
16	0	0	0	0	1	3	0	0
17-21	86	59	60	75	27	47	62	60
22+	5,375	5,159	4,785	4,673	6,417	6,795	6,874	6,077
Not specified	0	0	0	0	107	108	108	114
Total	5,461	5,218	4,845	4,748	6,552	6,953	7,044	6,251
Ethnicity								
White	4,133	4,017	3,801	3,765	5,677	6,048	6,180	5,540
Mixed	64	72	65	55	41	45	45	32
Asian or Asian British	681	622	517	485	158	166	167	106
Black or Black British	144	123	95	60	43	42	41	28
Other ethnic group	109	75	67	48	34	39	39	34
Not stated	115	134	162	186	599	613	572	511
Undefined	215	175	138	149	-	-	-	-
Total	5,461	5,218	4,845	4,748	6,552	6,953	7,044	6,251
Gender								
Female	4,350	4,175	3,887	3,833	4,369	4,629	4,663	3,953
Male	1,111	1,043	958	915	2,162	2,314	2,381	2,298
Not stated	0	0	0	0	21	10	0	0
Total	5,461	5,218	4,845	4,748	6,552	6,953	7,044	6,251
Disability								
No	3,530	3,164	2,754	2,436	-	-	-	-
Not declared	366	332	291	325	-	-	-	-
Undefined	902	1,088	1,225	1,370	6,036	6,389	6,265	5,670
Prefer not to answer	314	354	387	455	-	-	177	-
Yes	349	280	188	162	516	564	602	581
Total	5,461	5,218	4,845	4,748	6,552	6,953	7,044	6,251

Source: Electronic Staff Record and Civica membership database (as at 1/4/2024)

Disability and equal opportunities policies

The Trust is committed to a policy of equal opportunities in employment and service delivery. Everyone who comes to the Trust, either as a patient or visitor, or who works in the Trust, or applies to work in the Trust, should be treated fairly and valued equally. Our Trust policies and strategies (the equality delivery system, recruitment and retention of people with disabilities, supporting people who are trans policy and equal opportunities policy) all support this focus.

The Trust completes an annual action plan based on its performance against the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and gender pay gap reporting, the national NHS staff survey and other locally identified priorities. Our policies are under a cycle of continual review, and we are introducing a more formalised approach to undertaking Equality Impact Assessments of our policies, as well as wider Trust processes and decision making.

Gender pay gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31 March each year. You can download our gender pay gap report from the Trust internet: [WSFT Gender Pay gap report 2023 \(wsh.nhs.uk\)](https://wsh.nhs.uk)

The Trust seeks to provide equitable employment opportunities for people with disabilities, ensuring that they benefit from all available training and opportunities for career development WSFT also has a policy to support the recruitment and retention of people with disabilities. Additionally, our policies on appraisal, personal development planning and the knowledge and skills framework supports and promotes the equal access of all staff to training and development.

The Trust has systems and processes in place to review staff turnover. Information for the year is available here: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

2.8.9 Health and safety report

The Trust's health and safety performance is reported to, and monitored by, the health and safety committee which then escalates any issues of concern to the corporate risk governance group. Issues that cannot be resolved or which need to be escalated are reported to the insight committee and the Board of directors accordingly.

Risk assessment

The strategy for the management of risk continues to be developed and promoted Trust-wide. The Datix risk register is a tool for capturing, prioritising and managing the Trust's significant risks and is integral to the Trust's risk management framework. This will soon be replaced by Radar Healthcare.

The risk register allows all divisions to manage, monitor and review their own risks. The responsibility lies with each departmental manager to ensure all their significant risks are captured on the risk register. Risk register training is provided by the head of health, safety and risk and the Trust's health and safety advisor.

Between April 2023 to March 2024, 50 members of staff were trained in using the risk register. 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. 347 members of staff have now gained this qualification. Once completed, the inspection is captured on the risk register so actions can be monitored.

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR)

Between April 2023 to March 2024 17 incidents were reported to the Health and Safety Executive (HSE) as required under RIDDOR. This is an increase of four from the previous year.

There has been an increase in moving and handling incidents from three to six; violence and aggression by two incidents; health and safety by three incidents and asbestos by one incident. There has been a decrease for slips, trips and falls by five incidents; while needlesticks was the same number as last year with one incident.

RIDDOR description	2022-23	2023-24
Moving and handling incidents	3	6
Slips, trips and falls	7	2
Health and safety	2	5
Violence and aggression	0	2
Needlestick	1	1
Asbestos	0	1

The Trust continues to improve standards which has helped to prevent RIDDOR reportable incidents. This includes:

- level 2 award in health and safety training
- health and safety link persons in every department
- regular workplace inspections undertaken
- quarterly health and safety committee
- risk assessments captured on the Trust's risk register.

Of the 17 incidents reported to the HSE, nine (53%) were due to being off work for more than seven days following an incident and five (29%) were due to suffering a specified injury. The health and safety committee reviews incident trends, including RIDDORs to ensure that appropriate learning takes place and action taken.

Incident reporting system

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

For the period April 2023 to March 2024 there were 472 violence, abuse, and harassment incidents, an increase of 184 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 472 incidents reported there were 107 physical assaults, and 79 were recorded as having a clinical cause. Clinical-caused incidents are those whereby the patient is not aware or has no control of their actions. This can be postoperative due to having a general anaesthetic or, more commonly, because the patient is suffering from dementia or is cognitively impaired. The Trust has engaged with our staff networks to review how we manage unacceptable behaviour, including the support we provide to those affected.

There were 1,971 reported incidents of personal accident/ill-health during 2023-24. This is a decrease of 111 incidents (6%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories, which include slips/trips/falls, contact with an object, contact with a sharp, e.g. needle, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'. Further detail of learning and action is provided in section 1.2.3 (quality and operational performance).

2.8.10 Occupational health and wellbeing service report

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as being a marker of a good employer.

Our looking after our people group oversees a programme of action to support our staff. Our wellbeing workplan sets out our priorities. This has five key workstreams and a range of actions which draw from our framework assessment, staff survey, sickness and occupational health data, external guidelines and other key data sources. The five workstreams are:

- empowering colleagues to prioritise their own wellbeing
- fostering psychological safety
- preventative and inclusive interventions
- leadership support
- data informed decision making.

During 2023-24 we have progressed a range of activities, including:

- completing a Trust-wide assessment using the NHS Health and Wellbeing Framework diagnostic tool, with areas of good practice and improvement identified, and actions to take embedded within our wellbeing workplan
- the development of a comprehensive wellbeing workplan which will support the integrated development of activity moving forward
- renewing our contract with Abbeycroft Leisure, providing free access for staff to gym, swimming and fitness facilities at different locations, including online fitness classes. As of December 2022, 76% of our workforce were members, and we continue to encourage conversation to active/regular attendance. We are continuing to work closely with Abbeycroft to extend the offers available and also to measure more closely the impact across a range of staff metrics
- significant work on the development of a Workplace Adjustments Guide for leaders, managers and staff to support the wellbeing at work for disabled colleagues and those with a long-term health condition. Alongside this we have also developed a digital technology assistive toolkit
- wellbeing conversations have been embedded as part of our new appraisal framework and paperwork
- gathering and analysis of more data across a range of areas to guide and support decision making and prioritisation of actions
- ongoing promotion of menopause support
- delivery of a range of events to support health and wellbeing, including 'Love Yourself Week' in February 2024, which included sessions on gut health and the importance of sleep.

We have continued working in partnership with Workplace Health and Wellbeing, part of the Norfolk and Norwich University Hospitals NHS Foundation Trust, to provide comprehensive occupational health services for all our staff. Services have been delivered in a timely and professional way, with escalation of any issues dealt with promptly. An oversight group meets quarterly to review progress, matters arising and key performance indicators.

Our clinical psychologist-led staff support psychology service continues to provide ongoing support for staff during what continue to be challenging operational conditions.

2.8.11 Staff survey

The NHS staff survey is conducted annually. From 2021-22 the survey questions align to the seven elements of the NHS "People Promise", and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020-21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2023 survey among trust staff was 46% (2022: 41%).

Staff experience and engagement

The WSFT moved from a partial survey to a full census of all its staff for the 2019 survey. This was done so the Trust could better understand the thoughts of the staff on what was working well and how we can better improve our services for the benefit of patients and the public. The Trust encourages open and honest communication throughout the organisation. A number of methods have been developed to encourage all staff to feel that they can contribute:

- all staff update – two-weekly (monthly from November 2023) live briefing and opportunity to ask questions with members of the executive team and others
- Freedom to Speak Up Guardian and champions
- guardian of safe working for junior doctors
- senior independent director – non-executive director lead for whistleblowing
- electronic staff briefing issued at least once a week
- monthly medical director's bulletin for medical staff
- Green Sheet weekly staff newsletter (fortnightly from December 2023)
- staff recognition programme
- staff health and wellbeing focus groups
- staff networks – PRIDE (LGBT+), REACH (race, equality and cultural heritage)
- new Parent and Carer network established
- staff engagement on corporate social media, e.g., X (formerly Twitter) and Facebook (including a closed staff Facebook group)
- a telephone hotline and web-based reporting for raising concerns anonymously.

Response rate

For the 2023 survey the Trust utilised a mixed-mode (email/postal), full census survey of eligible staff members. The Trust has seen a significant increase in the response rate and is well above average.

	2023	2022	2021	2020
Our organisation	46%	40%	43%	45%
Average	41%	44%	46%	45%

2023-24, 2022-23 and 2021-22

Scores for each indicator together with that of the survey benchmarking group acute and acute community trusts are presented below.

Indicators (‘People Promise’ elements and themes)	2023-24		2022-23		2021-22	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.3	7.3	7.2	7.2	7.3	7.2
We are recognised and rewarded	6.0	6.0	5.8	5.7	5.9	5.8
We each have a voice that counts	6.7	6.7	6.6	6.6	6.7	6.7
We are safe and healthy	6.2	6.1	5.9	5.9	6.0	5.9
We are always learning	5.6	5.6	5.3	5.4	5.4	5.2
We work flexibly	6.3	6.3	6.0	6.0	6.0	5.9
We are a team	6.7	6.8	6.6	6.6	6.7	6.6
Staff engagement	7.0	6.9	6.9	6.8	7.0	6.8
Morale	6.0	5.9	5.8	5.7	5.9	5.7

Highest five benchmarked scores (compared to average)

The following table outlines the five questions in which the Trust scored well:

Top 5 scores vs Organisation Average	Org	Picker Avg
q22. I can eat nutritious and affordable food at work	63%	55%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	70%	63%
q25c. Would recommend organisation as place to work	65%	60%
q23a. Received appraisal in the past 12 months	86%	83%
q12b. Never/rarely feel burnt out because of work	34%	31%

Lowest five benchmarked scores (compared to average)

The following table outlines the five questions in which the Trust did not score so well:

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q13d. Last experience of physical violence reported	67%	71%
q19c. Organisation ensure errors/near misses/incidents do not repeat	63%	67%
q20a. Would feel secure raising concerns about unsafe clinical practice	67%	70%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	53%	56%
q23b. Appraisal helped me improve how I do my job	23%	26%

Areas of improvement/deterioration from prior year

The table below shows where the Trust scores have improved, and scores have improved significantly in five of the questions:

Most improved scores	Org 2023	Org 2022
q3g. Able to meet conflicting demands on my time at work	48%	41%
q3i. Enough staff at organisation to do my job properly	32%	26%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	49%	43%
q6c. Achieve a good balance between work and home life	58%	52%
q23c. Appraisal helped me agree clear objectives for my work	35%	30%

The table below shows where the Trust scores have declined, and scores have declined in all five of these questions:

Most declined scores	Org 2023	Org 2022
q3b. Feel trusted to do my job	90%	92%
q11a. Organisation takes positive action on health and well-being	61%	62%
q5b. Have a choice in deciding how to do my work	55%	56%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	75%	76%
q3d. Able to make suggestions to improve the work of my team/dept	73%	74%

Future priorities and targets

The staff survey results have been shared with our colleagues across the Trust. Divisions are reviewing their own feedback in detail with HR business partners leading on the development of divisional action plans to address local findings from the survey.

Following the large listening exercise 'What Matters to You 2', held at the end of 2022-23 a thematic analysis of this data was undertaken. The results of this analysis was then triangulated with the outcomes from the Trust-wide staff survey results, and a review of Freedom to Speak Up themes collected since 2020.

The bringing together of these rich data sources has enabled the Trust to listen in depth to what is important to staff and therefore determine what our future priorities should be. Six key themes emerged which were used to support the development of our WSFT people and culture priorities for 2023-24 and also informed the development and implementation of broader Trust objectives.

The staff survey results will continue to inform our WSFT people and culture priorities for 2024-25.

2.8.12 Pension liabilities for ill-health retirement

There were five ill-health retirements during the year to 31 March 2024 (2022-23: one); the additional pension liability borne by NHS Pensions was estimated as £644k (2022-23: £40k).

2.8.13 Policies and procedures for fraud and corruption

The Trust is committed to the elimination of fraud and corruption and is determined to protect itself and the public from such unlawful activities, whether they are attempted from within the Trust, or by an outside individual, group or organisation.

The Trust is committed to ensuring that opportunities for fraud and corruption are reduced to the lowest possible level by creating an anti-fraud culture that:

- deters fraud
- prevents fraud that cannot be deterred
- detects fraud that cannot be prevented.

To achieve this WSFT will:

- ensure that employees, contractors, suppliers and users of our services understand that fraud is unacceptable and that they are able to raise serious concerns easily
- share information with other trusts and organisations to deal with fraud and corruption locally and nationally, working within the law
- increase awareness of fraud and corruption through a programme of training and communication
- investigate all allegations of fraud and corruption in a professional manner
- apply appropriate sanctions such as disciplinary action, criminal proceedings and recovery of losses when necessary
- where appropriate, WSFT will publicise cases demonstrating the Trust's commitment to fighting fraud.

By creating an anti-fraud culture, the Trust will help ensure that money is not lost to the organisation that could have been invested in patient care. It will also provide an environment in which employees have the confidence to report any fraud concerns they may have.

To support this commitment the Trust has policies and procedures in respect of fraud and corruption as well as a Bribery Act policy. It also has a nominated local counter fraud specialist (LCFS) whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The LCFS reports to the audit committee. The assistant director of finance is the nominated fraud champion at the Trust.

2.8.14 Off-payroll engagements

As required by HM Treasury per Public Expenditure System (PES) (2022)01, the Trust must disclose information regarding off- payroll engagements.

Highly paid off-payroll engagements as at 31 March 2024 earning £245 per day or greater:

No. of existing engagements as of March 2024	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 and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
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	4

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater:

No. of off-payroll workers engaged during the year ended 31 March 2024	8
Of which:	
Not subject to off-payroll legislation	8
Subject to off-payroll legislation and determined as in scope for IR35	0
Subject to off-payroll legislation and determined as out of scope for IR35	8
No. of engagements reassessed for compliance or assurance purposes during the year	5
No. of engagements that saw a change to IR35 status following the consistency review.	0

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2024:

No. of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed Board members, and/or senior officials with significant financial responsibility, during the financial year. This figure should include both off-payroll and on-payroll engagements.	36

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

The Trust has reviewed all off-payroll arrangements and from 6 April 2017, all arrangements have been terminated or moved on to payroll unless they are assessed as meeting HMRC's requirements to be paid gross. There were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2023 and 31 March 2024.

During 2023-24, the Trust spent £393k on consultancy costs (2022-23 £396k). Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

2.8.15 Other disclosures

Other relevant disclosures for this section of the annual report are including within section 2.2 (directors report).

West Suffolk NHS Foundation Trust

Annual accounts for the year ended 31 March 2024

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Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2024, 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

A handwritten signature in blue ink, appearing to read 'Ewen Cameron', is written over a horizontal dotted line.

Name Dr Ewen Cameron
Job title Chief Executive Officer
Date 25 June 2024

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF West Suffolk NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of West Suffolk NHS Foundation Trust ("the Trust") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2024 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect.

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud (“fraud risks”) we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust’s high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust’s channel for “whistleblowing”, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust’s accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the majority of funding provided to the Trust during the year, and that other income streams are high volume transactions with a low value, and with simple recognition criteria which present minimal year end cut off risk. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to the completeness of non-NHS accrued expenditure. We consider there to be a completeness risk over non-NHS expenditure as there may be an incentive to under accrue expenditure at year end to help improve the reported position for the Trust and system.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included Journals with unexpected postings to cash or borrowings, Journals with unexpected postings to expenditure and unusual posting to accruals.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspection of a sample of invoices to expenditure in the period around 31 March 2024, to determine whether expenditure has been recognised in the correct accounting period.
- Selection of a sample of year-end accruals and inspection of evidence in regard to the actual amount paid after year end in order to assess whether the accrual has been accurately recorded in the correct period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations.

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer (as required by auditing standards), and discussed with the Accounting Officer the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer [and other management] and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the

requirements of the NHS Foundation Trust Annual Reporting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 110 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 110, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements

in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

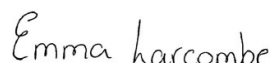
We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of West Suffolk NHS Foundation Trust for the year ended 31 March 2024 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Emma Larcombe

for and on behalf of KPMG LLP

Chartered Accountants

KPMG LLP

20 Station Road

Cambridge

CB1 2JD

27 June 2024

Statement of Comprehensive Income for the year ended 31 March 2024

		2023/24	2022/23
	Note	£000	£000
Operating income from patient care activities	3	360,326	353,715
Other operating income	4	36,981	29,913
Operating expenses	6	(211,724)	(116,346)
Employee Benefits	8	(276,702)	(259,671)
Operating (deficit)/surplus from continuing operations		(91,119)	7,611
Finance income		665	330
Finance expenses		(1,109)	(1,592)
PDC dividends payable		(5,463)	(5,148)
Net finance costs		(5,907)	(6,410)
Other losses		(493)	(820)
Share of profit of associates / joint arrangements		1,268	70
(Deficit)/surplus for the year		(96,251)	451
Adjusted financial performance (control total basis):			
(Deficit) / surplus for the period		(96,251)	451
Remove net impairments not scoring to the Departmental expenditure limit		89,638	(755)
Remove I&E impact of capital grants and donations		336	317
Remove net impact of inventories received from DHSC group bodies for COVID response		7	17
Adjusted financial performance (deficit) / surplus		(6,270)	30

Statement of Financial Position as at 31 March 2024

		31 March 2024 £000	31 March 2023 £000
	Note		
Non-current assets			
Intangible assets	10	57,724	61,869
Property, plant and equipment	11	130,806	193,976
Right of use assets	13	11,624	9,817
Receivables	14	7,158	6,001
Total non-current assets		207,312	271,663
Current assets			
Inventories		4,640	4,365
Receivables	14	20,378	41,871
Non-current assets for sale and assets in disposal groups		490	520
Cash and cash equivalents	15	9,315	7,895
Total current assets		34,823	54,651
Current liabilities			
Trade and other payables	16	(41,934)	(73,503)
Borrowings	17	(4,732)	(4,801)
Provisions		(58)	(64)
Other liabilities		(1,776)	(1,336)
Total current liabilities		(48,500)	(79,704)
Total assets less current liabilities		193,635	246,610
Non-current liabilities			
Borrowings	17	(44,049)	(48,038)
Provisions		(407)	(507)
Total non-current liabilities		(44,455)	(48,545)
Total assets employed		149,180	198,065
Financed by			
Public dividend capital		277,694	230,215
Revaluation reserve		11,941	12,054
Income and expenditure reserve		(140,455)	(44,204)
Total taxpayers' equity		149,180	198,065

The notes on pages 157 to 190 form part of these accounts.



Name	Dr Ewen Cameron
Position	Chief Executive Officer
Date	25 June 2024

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	230,215	12,054	(44,204)	198,065
Deficit for the year	-	-	(96,251)	(96,251)
Impairments	-	(2,495)	-	(2,495)
Revaluations	-	2,382	-	2,382
Public dividend capital received	47,479	-	-	47,479
Taxpayers' and others' equity at 31 March 2024	277,694	11,941	(140,455)	149,180

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	200,285	11,704	(44,655)	167,334
Surplus for the year	-	-	451	451
Impairments	-	(2,949)	-	(2,949)
Revaluations	-	3,299	-	3,299
Public dividend capital received	29,930	-	-	29,930
Taxpayers' and others' equity at 31 March 2023	230,215	12,054	(44,204)	198,065

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for year ended 31 March 2024

		2023/24	2022/23
	Note	£000	£000
Cash flows from operating activities			
Operating (deficit) / surplus		(91,119)	7,611
Non-cash income and expense:			
Depreciation and amortisation	6	14,815	13,450
Net impairments	7	89,638	(755)
Decrease / (Increase) in receivables and other assets		20,584	(26,996)
Increase in inventories		(275)	(791)
Decrease in payables and other liabilities		(20,628)	(3,878)
(Decrease) / Increase in provisions		(107)	120
Other movements in operating cash flows		-	(820)
Net cash flows from / (used in) operating activities		12,908	(12,059)
Cash flows from investing activities			
Interest received		665	330
Purchase of intangible assets		(10,537)	(3,448)
Purchase of PPE and investment property		(35,080)	(26,541)
Sales of PPE and investment property		25	12
Initial direct costs or up front payments in respect of new right of use assets		(3,120)	-
Net cash flows used in investing activities		(48,047)	(29,647)
Cash flows from financing activities			
Public dividend capital received		47,479	29,930
Repayment of loans from DHSC		(2,307)	(2,307)
Repayment on other loans		(462)	(451)
Capital element of finance lease rental payments		(2,020)	(4,041)
Interest on loans		(978)	(1,040)
Other interest		(29)	-
Interest paid on finance lease liabilities		(113)	(728)
PDC dividend paid		(6,279)	(4,580)
Cash flows from (used in) other financing activities		1,268	(505)
Net cash flows from financing activities		36,559	16,278
Increase / (decrease) in cash and cash equivalents		1,420	(25,428)
Cash and cash equivalents at 1 April - brought forward		7,895	33,323
Cash and cash equivalents at 31 March	15	9,315	7,895

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.3 Interests in other entities

The Trust has a 25% share in Collaborative Procurement Partnership Limited Liability Partnership (LLP) with three other NHS Organisations. The LLP was established in 2017/18 and the investment in this is not yet material to the Trust. Therefore assets have not been reflected in the accounts. A profit of £1,268k has been accrued for in 2023/24 (£70k in 2022/23).

My Wish charity has not been consolidated into the Trust's accounts on the grounds of materiality.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive (API) contracts.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the Trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end. The Trust received donated property, plant and equipment from the Department of Health and Social Care in 2020/21 but has not received any subsequently.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	7	86
Dwellings	7	85
Plant & machinery	5	25
Transport equipment	-	-
Information technology	5	10
Furniture & fittings	10	10

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	4	20
Software licences	4	10

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities**Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

Note 1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16.

Note 1.12 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 18 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.13 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.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

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

Note 1.14 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 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.16 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.17 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- **Equipment Deposits:** The Trust pays a deposit to an external company for equipment issued to patients in the community. If the equipment is returned and the company is able to re-use it, the deposit is returned. Based on experience in the last 8.5 years it is assumed that 75% of deposits outstanding at the balance sheet date will be recovered, which equates to £10.2m for 2022/23.

- **Valuation of Land & Buildings:** The Trust employs a professional Valuer to value all land and buildings and to estimate their useful economic lives which are used to calculate depreciation. Assets are revalued by the Valuer every five years. In 2023/24 a full valuation was undertaken. The value of the Trust's land and buildings equates to £86.99m as at 31 March 2024. Further details can be found in note 12.

The Trust does not consider to have undertaken any critical judgements in applying accounting policies that do not involve the estimates noted above.

Note 2 Operating Segments

The Trust has one operating segment; healthcare provision.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2023/24	2022/23
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	68,884	-
Income from commissioners under API contracts - fixed element*	210,072	248,490
High cost drugs income from commissioners	10,314	10,824
Other NHS clinical income	5,406	22,192
Community services		
Income from commissioners under API contracts*	39,821	34,953
Income from other sources (e.g. local authorities)	10,487	9,761
All services		
Private patient income	3,117	1,277
Elective recovery fund	-	7,130
National pay award central funding***	188	8,527
Additional pension contribution central funding**	10,887	9,824
Other clinical income	1,150	737
Total income from activities	360,326	353,715

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

	2023/24	2022/23
	£000	£000
Income from patient care activities received from:		
NHS England	43,464	43,677
Clinical commissioning groups (CCGs)*	-	66,346
Integrated care boards (ICBs)*	297,026	227,224
Other NHS providers	14,559	13,073
Local authorities	1,010	1,381
Non-NHS: private patients	3,117	1,277
Non-NHS: overseas patients (chargeable to patient)	278	229
Injury cost recovery scheme	872	508
Total income from activities	360,326	353,715
Of which:		
Related to continuing operations	360,326	353,715

* CCGs demised on 1 July 2022 and formed ICBs.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2023/24	2022/23
	£000	£000
Income recognised this year	278	229
Cash payments received in-year	99	52
Amounts added to provision for impairment of receivables	-	158
Amounts written off in-year	23	-

Note 4 Other operating income

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	567	-	567	776	-	776
Education and training	10,689	-	10,689	9,251	-	9,251
Non-patient care services to other bodies	21,229	-	21,229	14,658	-	14,658
Reimbursement and top up funding	-	-	-	210	-	210
Charitable and other contributions to expenditure	-	51	51	-	542	542
Other income	4,445	-	4,445	4,476	-	4,476
Total other operating income	36,930	51	36,981	29,371	542	29,913
Of which:						
Related to continuing operations			36,981			29,913

*Other income includes £1,629k of car parking (2022/23 £1,085k) and £1,167k of catering income (2022/23 £766k).

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24	2022/23
	£000	£000
Income from services designated as commissioner requested services	360,326	353,715
Income from services not designated as commissioner requested services	36,981	29,913
Total	397,307	383,628

Note 6 Operating expenses

		2023/24	2022/23
	Note	£000	£000
Purchase of healthcare from NHS and DHSC bodies		69	72
Purchase of healthcare from non-NHS and non-DHSC bodies		5,640	6,497
Staff and executive directors costs	8	276,702	259,671
Remuneration of non-executive directors		168	146
Supplies and services - clinical (excluding drugs costs)		35,665	36,251
Supplies and services - general		4,302	4,400
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		28,288	27,170
Consultancy costs		393	396
Establishment		9,222	6,610
Premises		8,734	6,179
Transport (including patient travel)		2,311	1,738
Depreciation on property, plant and equipment	11	8,685	10,649
Amortisation on intangible assets	10	6,130	2,801
Net impairments	7	89,638	(755)
Movement in credit loss allowance: contract receivables / contract assets		382	231
Increase/(decrease) in other provisions		15	48
Change in provisions discount rate(s)		2	-
Fees payable to the external auditor			
audit services- statutory audit*		160	153
Internal audit costs**		189	160
Clinical negligence		8,295	7,987
Legal fees		129	70
Insurance		123	11
Education and training		1,331	1,091
Expenditure on short term leases		-	111
Variable lease payments not included in the liability		1,411	3,872
Car parking & security		22	7
Hospitality		50	22
Losses, ex gratia & special payments		10	39
Other services, eg external payroll		322	-
Other		38	390
Total		488,426	376,017
Of which:			
Related to continuing operations		488,426	376,017

* The audit fee for 2023/24 is £126k plus VAT (2022/23 £126k plus VAT).

** All internal audit costs are non-staff related as the service is provided by an external firm.

Note 6.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2022/23: £1 million).

Note 7 Impairment of assets

	2023/24 £000	2022/23 £000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	85,462	(987)
Changes in market price	4,176	232
Total net impairments charged to operating surplus / deficit	89,638	(755)
Impairments charged to the revaluation reserve	2,495	2,949
Total net impairments	92,133	2,194

A full valuation was undertaken by Gerald Eve as at 31 March 2024. An impairment occurred on the Trust's land and buildings, which resulted in a reduction in asset value, as follows:

	Net Impairment £000
Main Hospital Block	85,194
Other Buildings - RAAC	2,313
Other Buildings - Non RAAC	4,086
Land	540
Total	92,133

The majority of the impairment relates to the main hospital block and is due to unforeseen obsolescence with the structure and the works required to bring the asset into repair and back in to use. The remaining life of the main hospital building and other RAAC related buildings has also been reduced. Land and other non RAAC related assets have fallen in value due to the current market.

Note 8 Employee benefits

	2023/24	2022/23
	Total	Total
	£000	£000
Salaries and wages	211,282	200,360
Social security costs	23,887	22,017
Apprenticeship levy	1,032	981
Employer's contributions to NHS pensions	35,817	32,356
Pension cost - other	95	86
Other employment benefits	157	-
Temporary staff (including agency)	7,019	6,253
Total gross staff costs	279,289	262,053
Recoveries in respect of seconded staff	-	-
Total staff costs	279,289	262,053
Of which		
Costs capitalised as part of assets	2,587	2,382

Note 8.1 Retirements due to ill-health

During 2023/24 there were 5 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £644k (£40k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at [s. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.](#)

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Note 10 Intangible assets - 2023/24

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	4,365	73,672	1,758	79,795
Additions	-	1,801	1,477	3,278
Reclassifications	-	1,201	(2,125)	(924)
Disposals / derecognition	-	(369)	-	(369)
Valuation / gross cost at 31 March 2024	4,365	76,305	1,110	81,780
Amortisation at 1 April 2023 - brought forward	894	17,032	-	17,926
Provided during the year	514	5,616	-	6,130
Disposals / derecognition	-	-	-	-
Amortisation at 31 March 2024	1,408	22,648	-	24,056
Net book value at 31 March 2024	2,957	53,657	1,110	57,724
Net book value at 1 April 2023	3,471	56,640	1,758	61,869

Note 10.1 Intangible assets - 2022/23

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	4,137	62,094	-	66,231
Additions	228	7,923	1,758	9,909
Reclassifications	-	3,655	-	3,655
Valuation / gross cost at 31 March 2023	4,365	73,672	1,758	79,795
Amortisation at 1 April 2022 - as previously stated	628	13,564	-	14,192
Provided during the year	266	2,535	-	2,801
Reclassifications	-	933	-	933
Amortisation at 31 March 2023	894	17,032	-	17,926
Net book value at 31 March 2023	3,471	56,640	1,758	61,869
Net book value at 1 April 2022	3,509	48,530	-	52,039

Note 11 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	9,210	116,040	14,744	39,929	17,717	10,118	135	207,893
Additions	-	12,453	-	12,503	5,628	1,822	-	32,406
Impairments	(510)	(89,761)	(2,367)	-	-	-	-	(92,638)
Reversals of impairments	-	473	62	-	-	-	-	535
Revaluations	-	(1,646)	(267)	-	-	-	-	(1,913)
Reclassifications	-	28,228	-	(29,765)	697	1,764	-	924
Disposals / derecognition	-	(150)	-	-	-	-	-	(150)
Valuation/gross cost at 31 March 2024	8,700	65,637	12,172	22,667	24,042	13,704	135	147,057
Accumulated depreciation at 1 April 2023 - brought forward	-	-	-	-	5,939	7,844	134	13,917
Provided during the year	-	3,996	299	-	1,493	841	-	6,629
Revaluations	-	(3,996)	(299)	-	-	-	-	(4,295)
Accumulated depreciation at 31 March 2024	-	0	(0)	-	7,432	8,685	134	16,251
Net book value at 31 March 2024	8,700	65,637	12,172	22,667	16,610	5,019	1	130,806
Net book value at 1 April 2023	9,210	116,040	14,744	39,929	11,778	2,274	1	193,976

Note 11.1 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	11,730	105,369	11,596	25,962	16,741	13,477	135	185,010
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	(6,930)	(3,655)	-	(10,585)
Additions	-	6,118	1,506	19,477	7,918	296	-	35,315
Impairments	(2,300)	(2,575)	(497)	-	-	-	-	(5,372)
Reversals of impairments	-	2,705	473	-	-	-	-	3,178
Revaluations	300	(874)	53	-	-	-	-	(521)
Reclassifications	-	5,297	1,613	(5,510)	-	-	-	1,400
Transfers to / from assets held for sale	(520)	-	-	-	-	-	-	(520)
Disposals / derecognition	-	-	-	-	(12)	-	-	(12)
Valuation/gross cost at 31 March 2023	9,210	116,040	14,744	39,929	17,717	10,118	135	207,893
Accumulated depreciation at 1 April 2022 - as previously stated	-	4	-	-	9,741	5,644	134	15,523
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	(4,380)	(770)	-	(5,150)
Provided during the year	-	3,566	250	-	590	2,970	-	7,376
Revaluations	-	(3,570)	(250)	-	-	-	-	(3,820)
Disposals / derecognition	-	-	-	-	(12)	-	-	(12)
Accumulated depreciation at 31 March 2023	-	-	-	-	5,939	7,844	134	13,917
Net book value at 31 March 2023	9,210	116,040	14,744	39,929	11,778	2,274	1	193,976
Net book value at 1 April 2022	11,730	105,365	11,596	25,962	7,000	7,833	1	169,487

Note 11.2 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	8,700	64,176	12,172	22,667	16,216	4,069	1	128,001
Owned - donated/granted	-	1,461	-	-	394	950	-	2,805
Total net book value at 31 March 2024	8,700	65,637	12,172	22,667	16,610	5,019	1	130,806

Note 11.3 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	9,210	110,524	14,744	39,929	11,568	2,274	1	188,250
Owned - donated/granted	-	5,516	-	-	210	-	-	5,726
Total net book value at 31 March 2023	9,210	116,040	14,744	39,929	11,778	2,274	1	193,976

Note 12 Revaluations of property, plant and equipment

A full valuation exercise on the land and properties comprising the West Suffolk NHS Foundation Trust estate was carried out with a valuation date of 31 March 2024. This valuation was undertaken by an external Valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book').

Property, Plant and Equipment on the Statement of Financial Position has a carrying amount of £131m. Within this, £77m is considered to be specialised property which is valued on a depreciated replacement cost basis. This includes the hospital sites and residences. Here the Valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

The key assumptions that are most likely to affect the valuations are:

- **Cost data:** The Valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the Valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher this would have an impact on the value of specialised properties recorded in the balance sheet of an increase of £3.8m.

- **Adjustments for obsolescence:** Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the Valuer based on his knowledge and experience, it takes into account physical deterioration, functional obsolescence and economic obsolescence. Had the adjustment for obsolescence been 2% higher than the Valuer assumed, this would have an impact on the value of specialised properties recorded in the balance sheet of a decrease of £5.3m.

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 useful economic life of the main hospital block has been reduced significantly due to the structural issues associated with reinforced autoclaved aerated concrete (RAAC). The range of useful economic lives by category of asset are detailed in note 1.7.

Note 13 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	6,408	8,992	-	-	15,400	2,865
Additions	3,120	-	-	-	3,120	-
Remeasurements of the lease liability	447	297	-	-	744	(63)
Valuation/gross cost at 31 March 2024	9,975	9,289	-	-	19,264	2,802
Accumulated depreciation at 1 April 2023 - brought forward	1,019	4,564	-	-	5,583	254
Provided during the year	850	1,206	-	-	2,056	349
Accumulated depreciation at 31 March 2024	1,869	5,770	-	-	7,639	603
Net book value at 31 March 2024	8,106	3,518	-	-	11,624	2,199
Net book value at 1 April 2023	5,389	4,428	-	-	9,817	2,611
Net book value of right of use assets leased from other DHSC group bodies						2,199

Note 13.1 Right of use assets - 2022/23

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	-	-	-	-	-	-
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	6,930	-	3,655	10,585	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	6,366	4,796	240	-	11,402	3,056
Transfers by absorption	-	-	-	-	-	-
Additions	29	289	-	-	318	29
Remeasurements of the lease liability	13	724	(240)	-	497	(220)
Reclassifications	-	-	-	(3,655)	(3,655)	-
Disposals / derecognition	-	(3,747)	-	-	(3,747)	-
Valuation/gross cost at 31 March 2023	6,408	8,992	-	-	15,400	2,865
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-	-	-
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	4,380	-	770	5,150	-
Provided during the year	1,019	2,091	-	163	3,273	254
Reclassifications	-	-	-	(933)	(933)	-
Disposals / derecognition	-	(1,907)	-	-	(1,907)	-
Accumulated depreciation at 31 March 2023	1,019	4,564	-	-	5,583	254
Net book value at 31 March 2023	5,389	4,428	-	-	9,817	2,611
Net book value at 1 April 2022	-	-	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies						2,611

Note 13.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 17.

	2023/24	2022/23
	£000	£000
Carrying value at 31 March	9,890	4,143
IFRS 16 implementation - adjustments for existing operating leases		11,403
Lease additions	-	318
Lease liability remeasurements	744	497
Interest charge arising in year	102	563
Early terminations	-	(2,265)
Lease payments (cash outflows)	(2,133)	(4,769)
Carrying value at 31 March	8,603	9,890

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on the Statement of Financial Position are disclosed in the reconciliation above.

Note 13.3 Maturity analysis of future lease payments

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2024	2024	2023	2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,964	358	2,045	357
- later than one year and not later than five years;	4,787	1,095	5,566	1,288
- later than five years.	2,208	829	2,686	973
Total gross future lease payments	8,960	2,282	10,298	2,619
Finance charges allocated to future periods	(357)	(90)	(408)	(111)
Net lease liabilities at 31 March 2024	8,603	2,192	9,890	2,507
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		2,192		2,507

Note 14 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables	12,086	34,370
Allowance for impaired contract receivables / assets	(636)	(298)
Deposits and advances	3,423	2,600
Prepayments (non-PFI)	4,232	2,793
PDC dividend receivable	748	500
VAT receivable	406	1,805
Corporation and other taxes receivable	109	93
Other receivables	10	8
Total current receivables	20,378	41,871
Non-current		
Deposits and advances	6,798	5,547
Other receivables	360	454
Total non-current receivables	7,158	6,001
Of which receivable from NHS and DHSC group bodies:		
Current	6,259	30,751
Non-current	360	454

Note 14.1 Exposure to credit risk

	31 March 2024 £000	31 March 2023 £000
Ageing of impaired financial assets		
0 - 30 days	32	0
31-60 Days	77	0
61-90 days	4	0
91 days- 1 year	287	139
1 year and over	236	159
Total	636	298
Ageing of non-impaired financial assets past their due date (not including accruals)		
0 - 30 days	4,010	18,109
31-60 Days	470	319
61-90 days	1,122	284
91 days- 1 year	852	761
1 year and over	135	638
Total	6,589	20,111

£4.7m of the non-impaired financial assets past their due date are owed by NHS organisations (£18.7m in 2022/23).

Note 15 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2023/24	2022/23
	£000	£000
At 1 April	7,895	33,323
Net change in year	1,420	(25,428)
At 31 March	9,315	7,895
Broken down into:		
Cash at commercial banks and in hand	7	7
Cash with the Government Banking Service	9,308	7,888
Total cash and cash equivalents	9,315	7,895

Note 16 Trade and other payables

	31 March	31 March
	2024	2023
	£000	£000
Current		
Trade payables	10,587	7,570
Capital payables	9,039	18,972
Accruals	12,715	37,618
Receipts in advance and payments on account	-	2,946
Social security costs	3,161	2,675
Other taxes payable	3,170	-
PDC dividend payable	-	568
Pension contributions payable	3,479	3,209
Other payables	(217)	(55)
Total current trade and other payables	41,934	73,503
Of which payables from NHS and DHSC group bodies:		
Current	4,960	4,758

Note 17 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Loans from DHSC	2,383	2,383
Other loans	472	461
Lease liabilities	1,877	1,957
Total current borrowings	4,732	4,801
Non-current		
Loans from DHSC	35,844	38,153
Other loans	1,479	1,952
Lease liabilities	6,726	7,933
Total non-current borrowings	44,049	48,038

Note 17.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Lease Liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	40,536	2,413	9,889	52,838
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,307)	(462)	(2,020)	(4,789)
Financing cash flows - payments of interest	(916)	(62)	(113)	(1,091)
Non-cash movements:				
Lease liability remeasurements	-	-	744	744
Application of effective interest rate	914	62	102	1,078
Carrying value at 31 March 2024	38,227	1,951	8,603	48,781

	Loans from DHSC	Other loans	Lease Liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2022	42,853	2,864	4,143	49,860
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,307)	(451)	(4,041)	(6,799)
Financing cash flows - payments of interest	(978)	(62)	(728)	(1,768)
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022			11,403	11,403
Additions	-	-	318	318
Lease liability remeasurements	-	-	497	497
Application of effective interest rate	968	62	563	1,593
Early terminations	-	-	(2,265)	(2,265)
Carrying value at 31 March 2023	40,536	2,413	9,889	52,838

Note 18 Clinical negligence liabilities

At 31 March 2024, £83,511k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2023: £85,843k).

The Trust also held £9k (31 March 2023: £36k) of contingent liabilities for legal claims managed by NHS Resolution.

Note 19 Contractual capital commitments

	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment	17,324	6,770
Total	17,324	6,770

Note 20 Carrying values of financial assets

	31 March 2024	31 March 2023
	Held at amortised cost	Held at amortised cost
	£000	£000
Trade and other receivables excluding non financial assets	23,313	43,277
Cash and cash equivalents	9,315	7,895
Total at 31 March 2024	32,628	51,172

£6.2m of the Trust's financial assets relate to income owed from other NHS Organisations (2022/23: £30.7m). Of the remaining balance as at 31 March 2024, £10.2m relates to deposits recoverable when community equipment is returned based on the likely proportion that will be returned.

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

There are no individually material debts owed by non-NHS Organisations and the risk profile of the asset is assessed as low, which is the same as in 2022/23.

Note 20.1 Carrying values of financial liabilities

	31 March 2024	31 March 2023
	Held at amortised cost	Held at amortised cost
	£000	£000
Loans from the Department of Health and Social Care	38,227	40,536
Obligations under leases	8,603	9,890
Other borrowings	1,951	2,413
Trade and other payables excluding non financial liabilities	34,419	67,149
Provisions under contract	95	109
Total at 31 March 2024	83,295	120,097

Borrowing excluding finance leases is at a fixed rate and, apart from £1.95m from a commercial loan provider, is from the Department of Health and Social Care.

There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as in 2022/23.

Note 20.2 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2024 £000	31 March 2023 £000
In one year or less	40,126	73,049
In more than one year but not more than five years	18,486	16,405
In more than five years	32,628	39,572
Total	91,241	129,027

Note 20.3 Fair values of financial assets and liabilities

The fair value of the financial instruments is based on book value (carrying value) because this is not considered to be significantly different to the initial transactions recognised.

Note 21 Losses and special payments

	2023/24		2022/23	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	60	13	1	1
Bad debts and claims abandoned	111	250	34	138
Stores losses and damage to property	3	240	3	267
Total losses	174	503	38	406
Special payments				
Extra-contractual payments	6	26	14	-
Ex-gratia payments	22	16	21	15
Total special payments	28	42	35	15
Total losses and special payments	202	545	73	421
Compensation payments received				

Note 22 Related parties

	Income		Expenditure	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
Cambridge Univeristy Hospitals NHS Foundation Trust	1,034	832	2,497	2,830
East Suffolk and North Essex NHS Foundation Trust	15,629	13,469	2,427	2,299
NHS Cambridgeshire and Peterborough ICB	4,121	2,823	213	-
NHS Norfolk and Waveney ICB	26,664	15,365	159	-
NHS Suffolk and North East Essex ICB	273,244	212,402	-528	11
NHS West Suffolk CCG*	-	60,084	-	-
NHS Ipswich And East Suffolk CCG*	-	15	-	-
NHS Norfolk & Waveney CCG*	-	5,018	-	-
NHS Cambridgeshire and Peterborough CCG*	-	923	-	2
Health Education England**	-	9,129	-	6
NHS England	39,263	36,175	89	25
NHS Resolution (formerly NHS Litigation Authority)	-	-	8,295	8,123
Total	359,955	356,235	13,152	13,296

	Receivables		Payables	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
Cambridge Univeristy Hospitals NHS Foundation Trust	512	105	1,354	700
East Suffolk and North Essex NHS Foundation Trust	2,087	1,702	554	458
NHS Cambridgeshire and Peterborough ICB	-	31	215	-
NHS Norfolk and Waveney ICB	47	8	159	-
NHS Suffolk and North East Essex ICB	850	18,111	1,402	1,629
NHS West Suffolk CCG*	-	-	-	-
NHS Ipswich and East Suffolk CCG*	-	-	-	-
NHS Norfolk and Waveney CCG*	-	-	-	-
NHS Cambridgeshire and Peterborough CCG*	-	-	-	-
Health Education England**	-	53	-	34
NHS England	802	8,848	200	455
NHS Resolution (formerly NHS Litigation Authority)	-	-	3	-
Total	4,298	28,858	3,887	3,276

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent £504k on behalf of the Trust (2022/23: £609k). At the year end the Charity owed the Trust £30k (2022/23 £54k).

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

* The CCGs demised on 1 July 2022 and formed ICBs.

**All transactions with Health Education England have been made through NHS England during 2023/24.

