11:10 BUILD A JOINED-UP FUTURE

18. West Suffolk Alliance Report update

To ACCEPT the report

For Report

Presented by Kate Vaughton

Trust Board Meeting - 26 July 2019

Agenda item:	18			
Presented by:	Kate Vaughton, Director of Integration and Partnerships			
Prepared by:	Jo Cowley, Senior Alliance Development Lead			
Date prepared:	19/07/19			
Subject:	West Suffolk Alliance Update			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update to the Board on the progress and development of the West Suffolk Alliance and partnership working in our system.

Main Points:

This paper provides an update on:

- Governance Review update
- Locality Development update
- Primary Care Network development
- Working together to improve services
- Wider partnership activity
- Mental Health Transformation

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x	**x**	**x**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x	x	x

Previously considered by:	Monthly update to board

Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The Board is asked to note the progress being made.	

West Suffolk Alliance Update

West Suffolk NHS Foundation Trust Board

26 July 2019

1.0 Introduction

1.1 This paper updates the Board on the progress and development of the West Suffolk Alliance and partnership working in our system.

2.0 Governance Review update

2.1 The alliance is reviewing some aspects of its governance. In part as a response to the development of the Integrated Care System (ICS), but also as a regular assurance process that the governance is fit for purpose for the alliance as it moves forward. The latest activity in this area includes:

- **A review of the Terms of reference and membership of the Steering Group and System Executive Group.** The System Executive Group (SEG) provides leadership for the alliance, takes responsibility for delivery of the alliance strategy[1] and the development of the senior level partnerships and relationships, which are needed to take joint working forward. Membership is drawn from a broad range of partners, reflecting the important role that is played by a wide number of organisations in the health and wellbeing of people in West Suffolk.

- **The Steering Group** has on it the senior leaders within the system who are responsible for delivery of services and the membership reflects this. The purpose of the meeting is to identify opportunities to improve system and partnership working to deliver the agreed Alliance strategy. The outputs from this group drive the SEG agenda in terms of agreeing options for discussion and agreement.

- A **System Finance Committee** has been established, which will bring together finance and clinical leads from across the alliance partners including district and borough councils. It will meet three times a year with the first meeting on the 31st July 2019. The draft terms of reference, which will be discussed and agreed at that meeting, are:

- Understand and monitor the use of health and care resources across the alliance
- Monitor the sub set of alliance expenditure which forms the West Suffolk alliance NHS control total providing early warning and assurance to the ICS of any risks to achievement
- Manage and oversee the alliance discretionary fund, keeping track of projects and progress and reporting to the West Suffolk SEG
- Look for opportunities for joint working in order to make best use of the West Suffolk pound
- Consider and recommend action on relevant financial benchmarking/improvement tools such as RightCare, NHS benchmarking, and social care prices
- Assure/complete/contribute to the ICS financial plan
- Monitor progress on alliance specific projects relating to finance as designated by SEG

[1] https://www.healthysuffolk.org.uk/uploads/West_Suffolk_Alliance_Strategy_(002).pdf

- **System Quality Committee –** a workshop with system partners took place in May to scope out how we could work together to drive quality improvement in health and care provision for people across West Suffolk. The outputs from the workshop are as follows:

    a. Recognition that there is data that can help us identify quality issues:
        i. Place Based Needs Assessments
        ii. Organisational risk registers
        iii. Integrated Population Health data
        iv. Customer experience and feedback (opportunity to bring this together alliance wide)
    b. The role of this group would be to identify:
        i. opportunities for quality improvement to create best quality and effective services,
        ii. where there are significant system quality risks
        iii. areas where we are stuck in terms of system change.
        iv. The group would also provide the lead governance forum for the system quality improvement programme supported by the Institute of Healthcare Improvement (IHI).
    c. This would lead to:
        i. task and finish groups to work up options for action, with the possibility of discussion at the Steering Group and then the System Executive Group.
        ii. Prioritisation through to the alliance strategy and action plan

    The group also discussed and agreed a set of principles to work to, and agreed to meet fortnightly in between System Executive Meetings. The first meeting is due to be set up shortly.

- **Joint CCG/WSFT meetings –** bringing together the Trust Executive Directors and the CCG Chief Officers on a routine basis to discuss issue together. This is to reduce duplication and to further develop the executive leadership team for health within West Suffolk. The first of these meetings took place on the 17th July.

- **New governance map –** the governance map for the Alliance has been refreshed and is attached as Appendix 1 to this report. This was presented to the wider Integrated Care System Board as part of the Kings Fund Governance review on 5th July.

- **Risk register –** the alliance risks have been drafted and a process to manage and review has been agreed, with oversight for this being held through the System Exec Group.

3.0 Locality Development update

3.1 Whilst the direction of travel for our localities has been agreed, getting pace on transformation can be difficult with front line teams managing business as usual, increased demand and pressures on recruitment to vacancies.

3.2 Named locality leads continue to work with front line team leads, GPs and wider partners to develop shared priorities, along with action plans, for their localities. A timeline has been agreed, which will ensure that appropriate planning has been done in each area, and this is attached as Appendix 2. Once agreed, task and finish groups will be established to take forward priority actions.

3.3 **Developing our locality workforce –** An example of partnership working in the localities is the development of six additional Health Care Assistants (HCAs) in the Mildenhall, Brandon, Newmarket and Haverhill localities to work with housebound patients including those in residential and nursing care. This group of people is particularly vulnerable to poor health outcomes and acute exacerbations of illness and frailty.

3.4 The HCAs are being recruited and employed by community services and their role will be to visit housebound and frail patients. They will carry out a variety of functions including blood tests, as well as gathering information on a number of health and care themes, including falls and memory assessments. This will allow for the identification of low-level issues, which if left unaddressed could lead to future problems, for example toe nail cutting. Information will be shared, with patient consent, with other agencies and parts of the health system will then be able to provide proactive input to support patients with their care and to support them to stay well.

3.5 As well as improvement in long-term care management, the HCAs will proactively be able to keep people in their homes, flagging a decline in systems and conditions before they reach crisis point. For the patient they are offering co-ordinated care.

4.0 Primary Care Network Development

4.1 The development of **Primary Care Networks** (PCNs) is an important component of our locality development.

4.2 Each PCN is now meeting regularly and starting to agree the practicalities of operating as a network, how they might share staff and work with others around the social prescribing and other opportunities. Four of our PCNs are working with LifeLink (the current social prescribing programme), with the final two yet to determine their delivery model.

4.3 A GP and primary care nurse education event was held at Newmarket Racecourse on the 13th June, for which we had our best level of attendance to date. The focus of the event was on mental health services, and the delivery of the West Suffolk Mental Health and Wellbeing Strategy.

4.4 To support the development of a locality leadership team in each of our six localities a leadership development programme, One Clinical Community (OCC), has been commissioned and is due to start in early autumn. The aim of the programme is to bring together the senior leaders from each part of the system at a local level to develop their own skills and begin to work together as a team to improve services for their population.

4.5 It is anticipated that participants will use the time together to begin to work through their priorities for the individual localities. The programme will be taught across four modules in a workshop style, which will focus on leadership and strategy; participants will be shown a range of practical tools and techniques to help them develop effective local plans, which will embed long-lasting change.

4.6 Between the modules there will be a joint enquiry day that will allow direct access to Alliance Leaders in the local system and provide an overview of the public health data and intelligence for the area. There will also be three action learning set days where each group will have a highly-experienced Action Learning Set adviser to support their programmes.

5.0 Working together to improve services

5.1 Many quality improvements come direct from clinical and professional leads spotting an issue and working together to fix it. Two examples illustrate this approach:

5.2 **Paediatrics –** Dr Lakshman (Consultant Paediatrician at West Suffolk Foundation Trust) and Dr Emma Ayers (a GP in Mildenhall) have joined forces to produce advice for GPs and patients around some common childhood problems. Topics covered so far include eczema, cows' milk protein allergy, hernias and toddler diarrhoea. GP practices have been asked to name Paediatric champions and a WhatsApp group has been set up to share regular

updates, tips and advice. Patient information leaflets are being developed and the options for making this a web-based resource is currently being looked into.

5.3 **Wound care in Primary Care –** Emma Williamson a Practice Nurse from Angel Hill GP Practice has developed a holistic wound care clinic with the aim of having "all patients with below-the-knee wounds healed within 12 weeks."

5.4 After reviewing RCN and NICE guidelines on best practice for wound care treatment and speaking to local district nurses, Emma concluded that a more efficient way to perform Doppler tests would bring huge benefits to patients and nurses. She requested funds for a Huntleigh Doppler machine, which allows one nurse to perform the test in 10 minutes, rather than two nurses in 30 minutes for the standard Doppler the practice already owned. Swift Doppler testing allows nurses to check whether patients can receive compression bandaging, a measure that can speed up wound healing. "The main stumbling block is the cost of the Doppler machine," Emma says. "I managed to convince the partners that with what we would save on nursing time it would be worth the investment – within the first few months it had paid for itself." Alongside the one-stop clinic, which the surgery now runs one day a week, Emma found other ways to improve wound care. "Training for practice nurses wasn't available locally to us," she says. "I pushed for us to be eligible for a two-day leg ulcer training course and arranged for patients to go to a local pharmacy to be measured for stockings. That's saved us time, and patients are saying the stockings are comfortable and they're actually wearing them." The efficient use of stockings and reduction in dressings needed means that from August 2018 to November 2018 the surgery's monthly spend on general supplies dropped by more than £1,000.

5.5 Emma has gone on to win the wound prevention and treatment category of the RCN Nurse Awards for 2019 and the success of the clinic has interested other local GP practices and Emma is keen to widen use of the model.

6.0 Wider Partnership Activity

6.1 At the SEG on the 3rd July, a trio of presentations stimulated a discussion about wider influences on health and wellbeing.

6.2 **Abbeycroft Leisure** talked about the partnership with West Suffolk Councils and other partners allowing them to develop new leisure premises that work hand in glove with other services. An example of this is the Haverhill Leisure Services, where Allied Health Professionals use their gym facilities for physical rehabilitation with patients, often leading them into longer-term use and higher rates of physical activity. The Active Mums project engages with pregnant women with a BMI> 25. The outcome of the pilot project was that, as well, as reduced weight gain, few mums had caesarean section (12.5% against Suffolk average of 23.8%) and 100% of mothers breastfed following the birth with 87.5% continuing after 6 – 8 weeks (Suffolk Average 36.7%). Abbeycroft are keen to continue to engage more and expand their partnership programmes.

6.3 Working closely with Abbeycroft are **LifeLink** who are delivering social prescribing in Haverhill. The project managers described to SEG the impacts of the work done to date. These include a measurable increase in participants' sense of wellbeing and a preliminary figure of an average of 25% reduction in GP visits for the individuals engaged with ther service compare to the control group (people referred but who did not take up). The outcomes are being verified by the University of Essex, and being the project rolled out to both Mildenhall and Brandon in August.

6.4 **End of Life** – Barbara Gale, Chief Executive of St Nicholas Hospice Care set out the arguments for us working together to improve experiences of dying and grief. The organisation is working on a new hospice model that allows people to be informed, equipped and able to live with dying, death and grief. They are piloting this new approach in

Mildenhall, using a strengths and community based approach. This has meant creating a "virtual ward" with community responders, working in localities and in care homes.

6.5 SEG gave their wholehearted backing to the three organisations presenting and agreed actions to be taken forward by the Alliance Steering Group to support development in each of these areas in line with the West Suffolk Alliance Strategy.

7.0 Mental Health Transformation

7.1 Work is ongoing to operationalise mental health and wellbeing strategy for Suffolk with the three headline areas of work being:

1. Immediate improvements to quality, safety and access

The immediate priority is to improve the care that people receive. We must ensure the safety of our services; regain the confidence of service users, families and carers; and support Norfolk and Suffolk Foundation Trust (NSFT), its new leadership team and its hard-working and dedicated staff to ensure this happens as quickly as possible.

NSFT has in place a detailed Quality Improvement Plan to respond to the areas highlighted by the Care Quality Commission (CQC) and this includes short-term and longer-term actions to address immediate safety and quality issues and to ensure improvements are embedded throughout the Trust are consistent and sustainable way.

2. A new model for delivering mental health – delivering our Mental Health Strategies

Significant work is underway with a number of investments made including:

- £2.6m in Improving Access to Psychological Therapies & Long Term Conditions – to expand access to psychological support particularly for people with a long term condition such as diabetes, heart failure and COPD by March 2021 increasing the access rate from 19% to 25%.
- £2.1m in the development of a Crisis Resolution and Home Treatment Team – development of 24/7 mental health crisis services enabling any resident to access support when they need it including home based assessment and support by March 2020.
- £1m to improve Early Intervention in Psychosis services – enabling a bespoke Suffolk wide team that support residents who suffer from psychosis early and prevent crises by June 2019.
- Finance is going into the voluntary and community sector and partners to support delivery of services to people for example information and advice for people with dementia through Dementia Together
- Early Adopter sites in Haverhill, Suffolk Coastal and Ipswich for developing and implementing a new primary care based integrated mental health service offer from autumn 2019.

3. Finding the right integrated model that will continue to deliver improvements

Both West and East Suffolk Alliances will be continuing to work with our Co-Production partners to ensure we continue to hear the voice of staff and service users, their families and carers to continue to shape this work.

To support this the alliance have developed a proposal to bring together a small implementation team seconded from within alliance organisations lead by a full time Programme Director, who came into post at the beginning of July.

The Alliances have agreed a timetable which seeks to transition to the new Mental Health model as set out within the Strategy from September 2020. To enable this to happen there are three distinct phases:

- ***June to end of September 2019***: Further development of the Mental Health operational model and the base case information e.g. finance, workforce and outcomes plus final draft service specification.
- ***October 2019 to end of January 2020:*** Due diligence process with the Alliances based on a series of half day meetings around themes.
- ***February 2019 to end of September 2020:*** Further development of the operational model and transition planning to new arrangement to go live end of September 2020.

8.0 Conclusion

The Board is asked to note the progress being made on individual initiatives and collaborative working across the system.

West Suffolk Alliance Governance – June 2019

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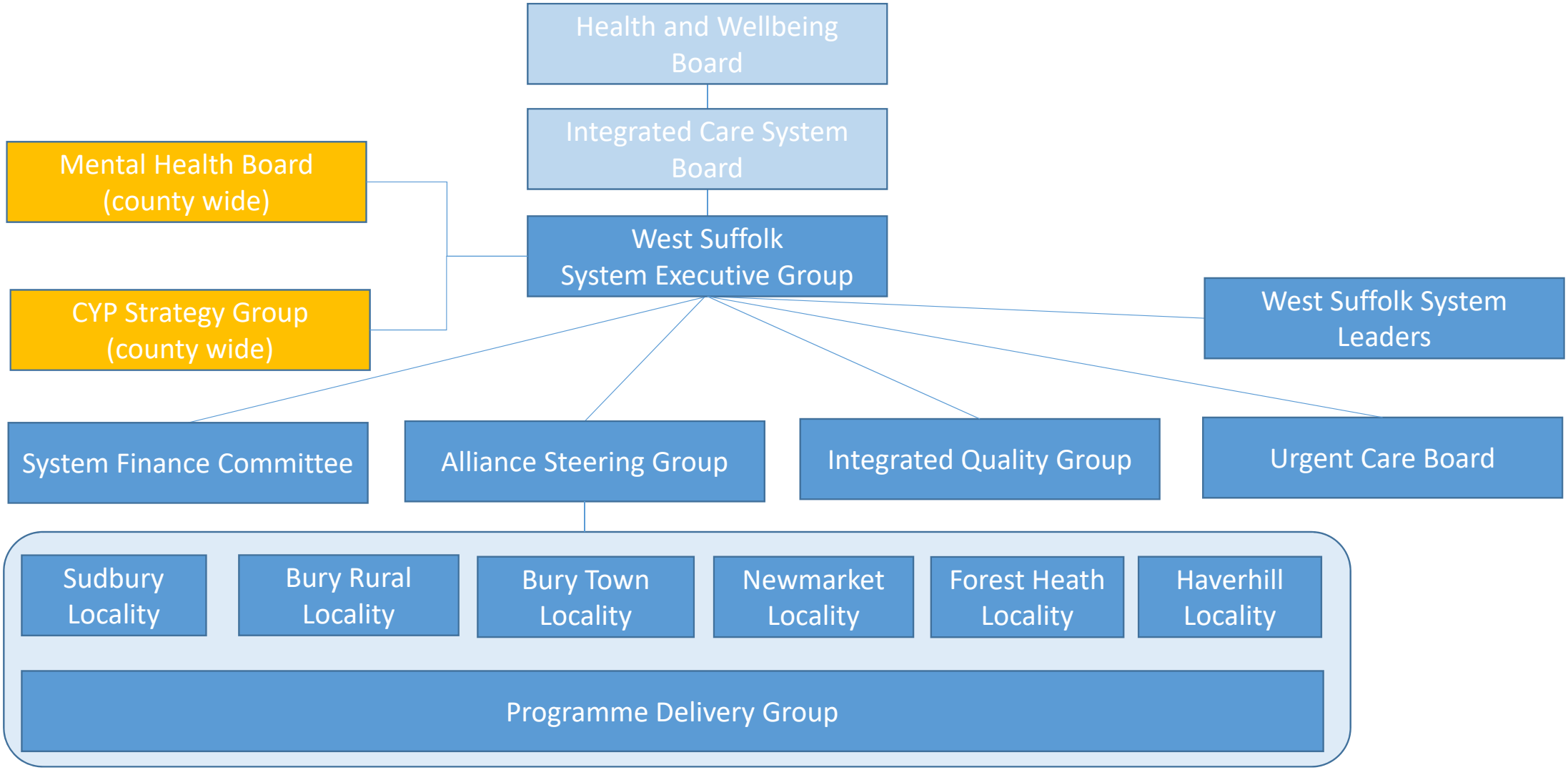
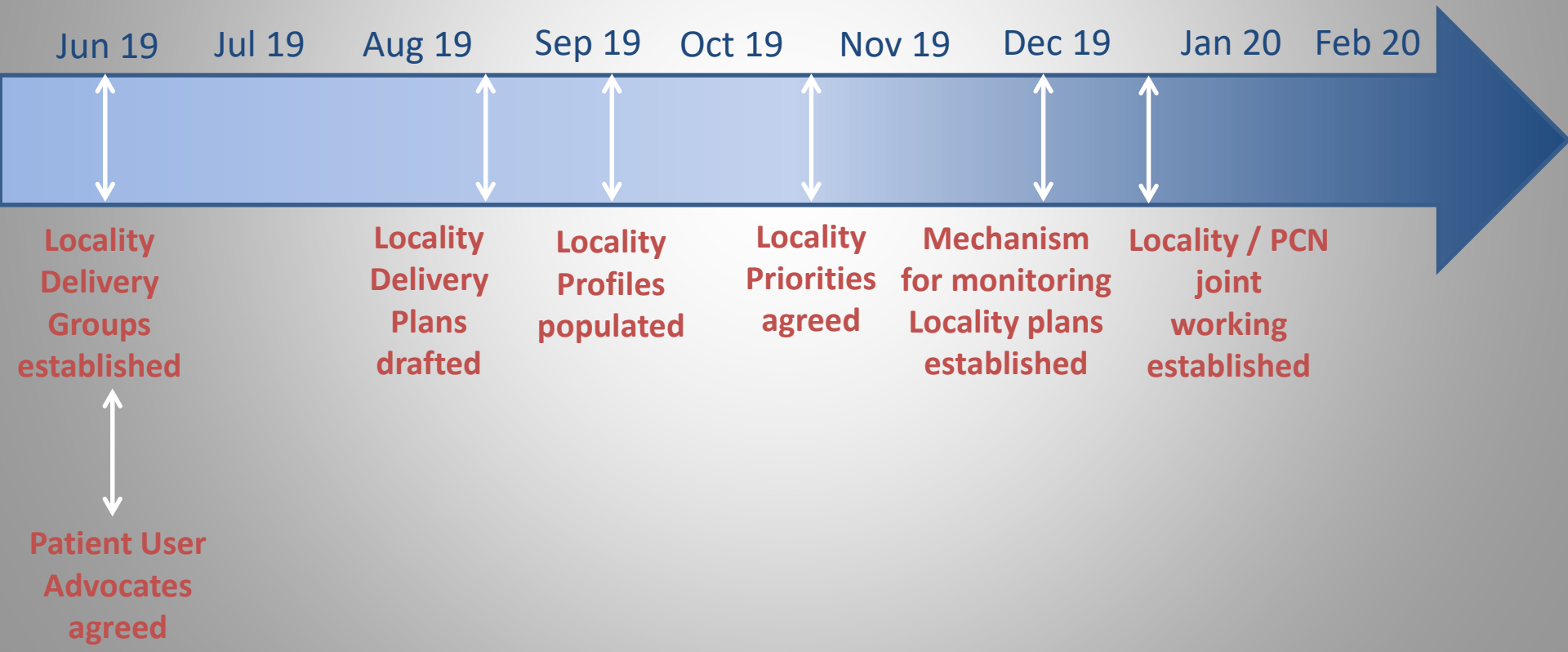
All about people and places



Localities Development Timeline



#TeamWestSuffolk

11:20 GOVERNANCE

19. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 26 July 2019

Agenda item:	19			
Presented by:	Craig Black, Deputy Chief Executive & Executive Director of Resources			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	19 July 2019			
Subject:	Trust Executive Group (TEG) report			
Purpose:		For information	X	For approval

Executive summary

1 July 2019

Steve Dunn provided an **introduction** to the meeting reflecting on a number of recent events. He described the positive feedback on the recent opening of the new staff accommodation blocks which were named to reflect the contribution of our staff - Beeton House, Bloomfield House and Clark House. He also praised the work on the extended AAU and refurbished labour suite which both looked fantastic. It was recognised that the AAU development had only been possible as a result of moving administrative offices into Quince House. Discussion also took place on the launch of Medic Bleep which, despite the concerns regarding Wi-Fi stability, had been very successful. The meeting considered the impact of the hot weather for staff and the need to ensure that we do everything we can to support staff within their work environment. It was noted that a review of options uniform is ongoing.

Quality, operational and financial performance was reviewed from the recent Board papers. The focus of quality discussions included timely completion of duty of candour and a review of the increase in complaints. It was noted that we have seen some improvements in the RTT, but the waiting list is growing. We have seen deterioration in the cancer performance, with high demand in urology and colorectal specialities as well as a challenging position to meet diagnostic demand. An update was received on ongoing work within the divisions to test and challenge capacity and demand analysis. This work is currently being finalised to support the RTT improvement plans. Discussion took place on the local and national experience from the new emergency department standards pilot. The headlines from the financial report were considered, including that we are £500k off plan after month two. The risk of failing to achieve the control target was discussed and recognised the need to maintain the focus on reducing agency costs.

The potential timing and schedule for the planned **CQC inspection** was reviewed. Divisions reflected on their self-assessments as part of their ongoing quality improvement work. It was noted that briefing sessions will be offered to staff later in July.

The business case for a **replacement rheumatology consultant** was approved. The opportunity is also being used to try and attract candidates with an interest in acute medicine.

A report from the **Quality Group** was received. It was welcomed that the West Suffolk Alliance had supported a system-based approach to delivery of quality improvement methods supported by the Institute for Healthcare Improvement (IHI). The quality assurance activities of the group were discussion and the areas for review from the recent CQC Insight report agreed.

An update was received on the **Allocate project** which supports job planning, appraisal and rostering. While experiencing some delays the progress was noted and agreed that focus must be maintained to

deliver the benefits for the scheme.

A report was reviewed which summarised the spring 2019 **7 Day Services (7DS)** audit results. Changes to the national reporting requirements were noted and a proposal for bi-annual audit programme supported. It was recognised that we have maintained improvement for standards two, five and six; underpinned by improvement in paediatrics.

15 July 2019

Craig Black provided an introduction to the meeting. Discussion took place on the ongoing work to support the delivery of mental health services locally while the commissioner-led tendering exercise is undertaken.

The **red risk report** was received. There were no new red risks. One red risk was downgraded as a result of mitigating action: 'timely provision of psychiatric assessment'. One draft red risk was noted. The corporate and operation risks were also reviewed which are subject to executive review and discussion at divisional performance review meetings. The key strategic risks identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation)
- **Winter planning** to ensure safe staffing and capacity for winter.
- **Pathology services** – delivery of pathology services, including MHRA inspection and NEESPS accountability and control. These all have an impact on service delivery and patients services directly impacting of quality and sustainability of services.

A report was received on the recent **rapid improvement event** which work with and support clinical areas as part of their quality improvement processes. Key areas for improvements were highlighted and discussed, including: staffing, environment/equipment and communication. A new initiative to support timely discharge was summarised - 'Get ready, get set, get home'. A key area of success from the pilot was ward based pharmacy, including support for medicines reconciliation and to-take-out (TTO) medication. Medicines reconciliation with 72 hrs improved to 95%, compared with 13% in baseline. With TTO turnaround of 32 mins compared with organisational average of 2 hrs. The transformation team are continuing to work with pilot wards to support their improvement plans (recognising some issues will require an organisational approach). Roll-out of the programme to next two areas is under way and it is anticipate that delivery will start to speed-up as the model becomes more established.

The **CQC self-assessment** submission was reviewed for each of the service areas. It was agreed that we need to provide visibility by service area for developments and improvements that have made. This will be shared with staff to provide a consistent corporate understanding.

An update was received on the **patient portal** which recognised that limited progress has been made since the pilot in 2018. This was due to changes in team and some technical issues that needed to be resolved. A project manager is now allocated and will be working with DrDoctor to deliver an outpatient platform to provide an improved solution for patients. A business case for the new proposal is being finalised.

The **review of wavers report** was noted and the basis of decisions to waive tendering discussed and challenged.

The updated **risk management strategy and risk assessment policy** were reviewed and approved. Updates reflect the changes to roles and responsibilities, including individuals and meetings. This is also reflected in the updated governance structure within the strategy (Annex). A change was also approved to the risk assessment policy so that accepted green (low) risks are reviewed every 24 months (rather than 12 months). Divisional governance handbooks were also received which underpin the risk management strategy and set out key roles and responsibility for each division.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receives a monthly report from TEG						
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Board note the report and approve the update risk management strategy							

Document ref. no: PP(19)093

Strategy and Policy for Risk Management

For use in:	All areas of WSHT
For use by:	All trust staff
For use for:	Management of all areas of risk to the Trust
Document owner:	Head of Governance
Status:	Revised

Summary

This document provides guidance on the Trust's risk management responsibilities and procedures to ensure risks are effectively identified, monitored and managed (controlled). Staff must ensure that risks are appropriately reported to managers. Managers must ensure that risks are properly assessed and as necessary escalated.

Risks are captured on the risk register as 'Operational' (risks local to an area or service), 'Corporate' (risks with a wide organisational impact) or 'Strategic' (risks to delivery of strategic objectives). Risks are rated as Red (high), Amber (medium) and Green (low) based on an assessment of the likelihood and consequence (harm) of a risk materialising. This risk rating informs the escalation requirements. Monitoring arrangements are in place to ensure that risks are appropriately reviewed and agreed action taken.

These arrangements ensure that staff, patients and others (others include visitors and contractors) are protected through the delivery of high quality and safe services.

Contents

1. Introduction

The Trust is committed to ensuring the safety of staff, patients and others through an integrated approach to managing risk, regardless of whether the risk relates to the delivery of patient care or achievement of business objectives. Good arrangements for risk management underpin the Trust's ability to identify and manage its risks in a robust manner.

Healthcare is a hazardous environment; it brings together sick and vulnerable patients with medical services often using complex technology and requires the effective coordination of many people. Complex systems in any industry are prone to human error. No matter how committed, skilled and hard working the staff, the complexity of modern NHS care and the nature of human behaviour means that incidents do happen and errors are made. Very few errors are due to a lack of care or commitment from healthcare professionals or from a desire to deliberately harm patients.

Therefore, the Trust operates effective risk management systems and a positive learning environment that supports improvements in patient care and safety which will reduce the level of risk. The Trust's objective is to manage risk as part of normal line management responsibilities which are monitored by the Trust's committee structure with risk escalated in an appropriate and timely fashion. Funding must be appropriately prioritised to mitigate/address 'risk' as part of the management and business planning processes. To support this the Trust has appropriate policies and procedures in place to eliminate or minimise risk and these should be followed by staff who will be provided with the necessary training. The Trust uses a Risk Register to log and effectively manage the information from risk assessments to enable the prioritising and monitoring of actions.

Definitions

Risk management is the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to eliminate, minimise, monitor, and control the probability and/or impact of incidents. Risks can come from uncertainty in financial markets, project failures, equipment failure, infrastructure limitations, accidents, natural causes and disasters as well political climate changes to name but a few.

The purpose of risk assessment is designed to identify hazards and to evaluate if enough protective measures are in place, or if more should be done to prevent harm to staff, patients and others.

A **hazard** is something that has the potential to cause injury, illness, harm or damage e.g. electricity, working from height, a piece of sharp equipment etc.

Risk is comprised of two elements: the likelihood that a hazard will actually cause injury, illness, harm or damage and the severity of the consequence of that harm. The hazard may be the same but the risk is different depending upon the circumstances / environment. For example, used needles left on work surfaces represent a serious risk, however, needles correctly placed in sharps containers are normally of low risk.

Risks fall broadly into three categories as defined in the Datix Risk Register:

- **Operational**: risks identified within a specific area e.g. ward or department
- **Corporate:** risks found to apply in a number of areas across the Trust and therefore being assessed and managed at a wider, organisational, level. Examples include trust wide management of patient safety priorities (e.g. falls) or compliance with health & safety legislation.
- **Strategic**: risks to the delivery and success of the Trust's strategic objectives

Within each of these categories, risks can be identified which relate to a range of topics, such as patient care, health, safety and welfare, environmental, information governance, business continuity and finance.

2. Background

Effective risk management is vital to the provision of high quality services and ensuing the success and sustainability of the Trust. Therefore identification, control and management of risk is fundamental. To achieve effective risk management the Trust requires a systematic approach to clinical and non-clinical risk management by maintaining and improving the quality of staff and patient care and ensuring that other types of risk are identified and managed appropriately.

Under the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999 the Trust has a legal duty to identify risks to health, safety and welfare and ensure so far as is reasonably practicable that these are eliminated, mitigated and managed appropriately to safeguard the health, safety and welfare of staff, patients, and others on Trust premises who could be affected by its undertakings. Health, safety and welfare risks will largely fall into the category of 'operational risk' but may also be considered in some cases be a risk to a Trust strategic objective.

NHS organisations also need to take into account the standards and requirements issued by the Department of Health and other regulatory bodies (such as NHSI and the Care Quality Commission (CQC)).

3. Aims

- To support the delivery of high quality services and protect staff, patients and others through an integrated approach to risk management (whether the risk relates to patient care, health, safety and welfare, environmental, information governance, business continuity and finance)
- To support achievement of the Trust's strategic objectives as set out in the assurance framework.
- To clearly define roles and responsibilities for the management of risk.
- To ensure that risk management methods are clearly understood and systematically applied throughout the Trust.
- To ensure that risks are identified, evaluated and prioritised for action.
- To establish clear and effective communication that enables information sharing.
- To foster an open culture that supports organisational risk identification and learning, including incident reporting.

4. Objectives and implementation

All Trust policies and procedures (including Health, Safety and Welfare, Nursing, Financial and Personnel) are relevant to risk management. Following appropriate standards, national and statutory guidance and best practice identified in policies and procedures will so far as is reasonably practicable minimise risk.

The implementation of the risk management strategy will be achieved through:

1. Developing robust arrangements in all divisions for managing and as appropriate escalate risk.
2. Undertaking effective monitoring of these risk management arrangements.
3. Providing training and support to managers to enable them to manage risk as part of normal line management responsibilities.
4. Undertaking suitable and sufficient risk assessments systematically in all divisions to identify hazards, and through effective controls eliminate or minimise risk.
5. Capturing risks on the Trust's Datix Risk Register. Ensuring that any decision to accept risk is taken appropriately and that prioritisation of funding, where required to manage identified risks, takes place as part of the management process and business planning arrangements.
6. Through business continuity arrangements ensure that procedures exist for establishing contingency plans.
7. Ensure that all staff groups within the Trust systematically report incidents on Datix.

8. Use information from risk assessments, incidents, complaints, audit (clinical and non-clinical), claims and other relevant internal and external sources to improve safety and facilitate Trust learning.
9. Use root cause analysis techniques to investigate certain incidents and claims. Ensuring learning takes place and is shared across the Trust and more widely.
10. Ensuring that there are appropriate policies and procedures in place that are communicated to and followed by staff to identify, eliminate or mitigate risk.
11. Improve compliance with risk management assessment frameworks and benchmark performance with other organisations:
    a) Supporting registration with the Care Quality Commission for the delivery of healthcare
    b) Supporting licensing by NHSI for the delivery of healthcare
12. Foster cross-organisational learning through appropriate information sharing and representation on local forums.
13. Mitigate the adverse financial consequence of a risk through the appropriate use of “insurance” arrangements.
14. Utilise internal and external audit, and other external regulatory and assessment bodies to provide assurance of the implementation and effectiveness of controls to eliminate or minimise risk.

5. Risk Management procedures

5.1 Risk identification

Risks can be identified from many different sources. Effective risk management allows these various sources to drive a single co-ordinated approach to the identification, assessment, elimination or the reduction of risk. Some of the potential sources are described below.

- Risk assessments for operational (local), corporate (trust-wide) and strategic risks
- Clinical and non-clinical incident reporting (including near misses), accidents, fire and security
- Concerns identified through complaints, litigation, inquests and internal whistle-blowing
- Feedback from patients and stakeholders, including patient and staff surveys
- Clinical audit findings
- Workplace inspections and health & safety compliance self-assessments, undertaken as part of the H&S monitoring programme
- National recommendations and guidance, including confidential enquiry recommendations safety alerts and NICE guidance
- Benchmarking, clinical indicators and performance assessments
- External and strategic risks through PEST and SWOT analysis of the annual plan
- External and Internal Audit reports
- Assessment against Care Quality Commission’s standards
- Care Quality Commission inspections, improvement review reports and benchmark analysis (Insight)
- Compliance with performance targets and regulatory requirements of: the Department of Health, NHSI and the CQC.
- Results of information governance assessments (e.g. data confidentiality, quality and security).
- Information from disciplinary procedures, grievances and harassment cases
- External regulatory and assessment body inspections and reviews, including Royal Colleges, Post Graduate dean reports; accreditation inspections and Health and Safety Executive (HSE) reports

Aggregated data from each of these sources informs operational, corporate and strategic risk management priorities. For example aggregated information from incidents, complaints and claims would inform a programme to undertake/review risk assessment activities for an area.

5.2 Management options

Risk transfer
Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place to eliminate or reduce the risk the Board will consider whether the activity should continue in the Trust. An example of such a risk avoidance measure would be the decision that patients requiring certain high-risk surgical procedures for which the required level of surgical expertise or equipment is not available in the Trust will be referred to a tertiary centre for their treatment. In this case a balance of risk must be considered – the risk from transferring the patient must be less than the risk of operating in the Trust environment.

Risk reduction
Where a risk is identified that cannot be eliminated or avoided the Trust must consider whether there are suitable and sufficient control measures in place. If there are not, then the Trust must consider how better control measures may be applied in order to reduce the risk. Making and carrying out risk reduction action plans is the responsibility of the line manager.

Risk acceptance
When all reasonable control mechanisms have been put in place, some residual risk will inevitably remain in many Trust processes. This level of risk must be accepted. Risk acceptance by the Trust will be systematic, explicit and transparent. The financial consequences of risk acceptance will be managed through participation in NHS Litigation Authority insurance schemes.

5.3 Risk assessment

The Trust has an agreed Risk Assessment Policy and Procedure (PP132), which sets out:

- how all risks are assessed
- how risk assessments are conducted consistently
- authority levels for managing different levels of risk within the organisation
- how risks are escalated through the organisation
- how the organisation monitors compliance with all of the above

All risk assessments must be captured and maintained on the Trust's electronic Risk Register (Datix). For clarity this includes operational, corporate and strategic risks.

Risk Rating:
To assist in prioritising risks the following formula is used:-
Likelihood x Consequence (severity) = **Risk Rating (RR)** - as seen in the matrix below:

Scoring Matrix

Likelihood of harm	Consequence of harm				
	Negligible	Minor	Moderate	Major	Catastrophic
20-Yearly	Green	Green	Green	Green	Green
5-Yearly	Green	Green	Green	Amber	Amber
Annually	Green	Green	Amber	Amber	Red
Quarterly	Green	Green	Amber	Red	Red
Weekly	Green	Green	Amber	Red	Red

Action required to reduce risk rating

Green (low)	Escalate to **ward/department manager or equivalent** to: • Implement additional controls whenever possible to reduce reduce/eliminate (through routine procedures). Funded by Division or escalated if required. • Review progress of "active" risk assessment as appropriate, including the implementation of additional controls (minimum every 12 months) • Accept risk if mitigated as far as reasonable practical. "Accepted" risk assessment to be reviewed as appropriate* (minimum every 12 months)
Amber (medium)	Escalate to **Service Manager, Head of Department or equivalent** to: • Implement additional controls whenever possible to reduce/eliminate risk (as soon as reasonably practicable). Funded by Division or escalated if required. • Review progress of "active" risk assessment as appropriate, including the implementation of additional controls (minimum every six months) • Accept risk if mitigated as far as reasonable practical. "Accepted" risk assessment to be reviewed as appropriate* (minimum every 12 months)
Red (high)	Escalate to **Director, Assistant Directors of Operations or equivalent** to: • Implement additional controls whenever possible to reduce/eliminate risk (as soon as reasonably practicable). Funded by Division or escalated if required. • Review progress of "active" risk assessment as appropriate, including the implementation of additional controls (minimum every three months). • **Escalate to Board** to "Accept" risk if mitigated as far as reasonable practical. "Accepted" risk assessment to be reviewed as appropriate* (minimum every 12 months)

After management action at a divisional level, issues that continue to pose a significant risk to the Trust (risk rating of Red (high) following the implementation of all identified controls) will be escalated to the Trust Executive Group (TEG) for deliberation and recommendation.

Appendix B sets out the escalation framework ensuring timely escalation of risks from wards, divisions or specialist committees. Red risks must be escalated to TEG as soon as identified through the relevant Assistant Directors of Operations (ADOs) or Clinical Director (for divisions) or Directors (for specialist committees).

If TEG concludes that the risk cannot be controlled the matter will be escalated to the Board for consideration or **acceptance**. This consideration will also agree appropriate monitoring arrangements. Red (high) risks considered by TEG will be reported to the Board as part of the Red risk report.

5.4 Risk Register and Assurance Framework

All risk assessments must be captured and maintained on the Trust's electronic Risk Register (Datix). For clarity this includes operational, corporate and strategic risks.

The risk register will be used and reviewed at all levels, including: the Board, Trust Executive Group, Divisions and Departments/Wards. As such, the risk register allows risks to be systematically recorded, managed and escalated. This intelligence is incorporated into the Trust's strategic and business planning processes at division and corporate levels.

Reporting from the risk register ensures appropriate escalation of risk according to the risk rating as set out in section 5.3. As well as reports to TEG, this will include reports to Division Governance Steering Groups and exception reporting to Divisional Executive Performance meetings if risk reduction action plans are not implemented or if risk assessments are not reviewed in accordance with agreed timeframes.

In addition to the escalation of individual risk assessments a quarterly review of the risk register is presented by the Health, Safety and Risk Manager to the Corporate Risk Committee to identifying trends, as well as review performance in risk identification, escalation and mitigation.

The Risk Register is monitored as follows:

- Trust Executive Group: All high (red) risks (monthly)
- Corporate Risk Committee: All high (red) risks (quarterly)
All medium (amber) "corporate" risks (quarterly)
- Quality & Risk Committee: All "red" risks (operational and corporate)
- Board of Directors: All risks scoring high (red)

New risks scoring high (red) are highlighted in the risk and governance report to the Board..

Risks to the Trust's strategic objectives are managed through the **Board Assurance Framework (BAF)**. The Board and its committees review the progress in controlling risks to strategic objectives and plans to mitigate the impact on the Trust should the risks materialise.

The Audit Committee receives assurances that these reporting arrangements are effectively capturing, managing and escalating risks.

5.5 Assurance

As part of the process for managing risk, consideration must be given to the level of independent assurance for the effectiveness of identified controls. The level of assurance expected will be influenced by the nature of the risk e.g. risks at the strategic or corporate level will require greater assurance.

The Trust will seek assurance that hazards are being appropriately identified and managed through the following:

- Receipt by relevant committees of reports for activities detailed in the Risk Management Strategy (section 5.1).
- Receipt by the Quality & Risk Committee of the minutes of the sub-committees, including where appropriate reports from specialist committees (see section 6.1).
- Quarterly review of the Trust's Quality Memorandum by the Quality & Risk Committee. This document describes the Trust's framework to monitor and assure quality.
- Findings of Internal and External Audit reviews informing the Audit Committee, priorities for these reviews informed by the assurance framework and risk register.
- The Annual Governance Statement (AGS), supported by Quality & Risk Committee, External and Internal Audit work programmes.
- Compliance with regulatory requirements, including Care Quality Commission and NHSI.
- Findings of external reviews and reports regarding the Trust's practices and procedures.
- Achievement of the Trust's strategic objectives as set out in the assurance framework.
- Review of the Risk Register and Assurance Framework demonstrating progress with additional controls to eliminate or minimise risk.

6. Roles and responsibilities

The Trust's governance structure for managing risk is outlined in the chart at Appendix A. The following section outlines key roles and responsibilities of individuals and committees to ensure the systematic implementation of the processes for the management of risk at all levels of the

organisation. Critical to any governance system is the ability to identify and escalate and manage risk in a timely and effective way. Appendix B sets out the framework for this within the Trust.

6.1 Corporate responsibilities

Chief Executive, Executive Director of Resources, Finance & Information and Executive Chief Nurse

The overall responsibility for effective risk management in the Trust, meeting all statutory requirements and adhering to guidance issued in respect of risk lies with the Chief Executive. At an operational level, the Executive Chief Nurse is the Director designated with responsibility for governance and risk management. Accountability for management of financial (business) risk including the correct application of Standing Financial Instructions and Standing Orders lies with the Executive Director of Resources.

The Executive Chief Nurse will liaise with the Executive Medical Director for medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery.

Trust Board
The Board is collectively responsible for promoting the success of the Trust by directing and supervising the organisations affairs. This responsibility is achieved through:

- providing active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.
- setting the organisation's strategic aims, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- setting the organisation's values and standards and ensuring that its obligations to patients, the local community and the Secretary of State are understood and met.

The Board has delegated some of its powers to formally constituted committees. These committees have a remit and decision making powers defined by the Board and report back to it at agreed intervals. The Board remains responsible for considering and accepting high (red) risks escalated through the risk management procedures.

Audit Committee
The committee will provide an independent and objective view of the Trust'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.

Quality & Risk Committee
The committee will monitor and review the Trust's quality performance indicators relating to patient safety, clinical outcome & effectiveness, and patient experience. This includes infection control and the review feedback to the Trust on the experience, including patient and staff surveys and complaints.

Scrutiny Committee
Oversees a work programme, determined by the Board of Directors, to support the delivery of the Trust's strategic objectives. This includes scrutinising and providing strategic advise/steer on these projects.

Digital Programme Board
Sets the overall strategic direction for the Trust information management and technology agenda and the associated transformation programme to facilitate technology enabled change. The digital board is clinically led, chaired by the Chief Executive and provides a high level of clinical and business

engagement to ensure that all elements of the IM&T strategy are aligned with the trust strategy and annual business plans.

Remuneration Committee
Sets remuneration for Executive Directors and considers organisational remuneration issues.

Charitable Funds Committee
Ensure appropriate management and control of charitable funds in accordance with the requirements of Charitable Commission guidance.

The following committees are subcommittees of the Quality & Risk Committee, and provide assurance on their performance through submission of their minutes and reports. Non-Executive Directors who are members of the Quality & Risk Committee and Audit Committee are also members of these subcommittees.

- **Clinical Safety & Effectiveness Committee (CESC)**
  To ensure that the Trust's clinical procedures and practices are effective in protecting staff, patients and others by ensuring that they comply with national requirements, promote best practice and are effective in the identification and elimination or reduction of hazards.

- **Corporate Risk Committee (CRC)**
  To ensure that the Trust's risk management, financial and workforce procedures are effective in promoting good business standards, protect the organisation, staff, patients and others, and comply with national standards and guidance.

- **Patient Experience Committee (PEC)**
  To ensure first rate customer and patient experience through the implementation of patient experience and Patient's First initiatives.

Executive committees

Executive Directors Meeting
The Executive Directors Meeting consists of the executive director team of the Trust, and is corporately responsible for formulation and delivery of the Trust's strategy, service aims and objectives as approved by the Board of Directors. This includes:

- **developing the direction, vision, plans & priorities for the organisation**
- **considering and responding to external/regulatory requirements**
- **considering recommendations to address service challenges and opportunities from divisions.**

Trust Executive Group (TEG)
Consisting of the senior management team of the Trust, TEG is corporately responsible for delivery of service quality and sustainability through the formulation, implementation and delivery of the Trust's strategy, service aims and objectives as approved by the Board. This includes performance managing and reviewing specific quality issues highlighted by and through Divisions, setting the direction, vision & scope for the transformation programme, performance managing at a corporate level the Cost Improvement Plans (CIPs) and acting as the forum for agreeing and planning future cost reduction and efficiency activities.

Risks are escalated for consideration by TEG via the subcommittees of Quality & Risk Committee, Audit Committee, Divisions, specialist committees and other Executive Committees according to the criteria set out in section 5.4. **Action available to be taken by TEG includes:**

- **Escalating a high (red) risk that cannot be eliminated or reduced to the Board for consideration or acceptance**

- Agreement of funding to implement additional controls to eliminate or mitigate the risk
- Amending risk ratings (after an informed discussion has taken place) to ensure that risks are rated appropriately.

TEG will also review summary reports of risks being managed at strategic and operational levels. This will include "top risks" for divisions and wards. Annually TEG will receive divisional governance handbooks for review and approval.

Transformation Steering Group
The combined CCG/WSFT transformation programme comprises workstream/portfolio including transformation/re-design plans, CIP/QUIP schemes, benefits realisations from e-Care and recommendations from the Carter review. The programme aims are:

- Delivery of financial plans
- Development of future financial sustainability including demand management plans
- Support for sustainable delivery of mandated performance targets
- Service re-design for quality
- Support to STP and West Suffolk ACO programme.

Specialist advisory committees
The Trust has established a number of specialist committees/groups. Each committee provides a forum for discussing quality, risk and other issues where expert opinion can be sought. Issues that individual committees are unable to resolve can be escalated to the responsible committee. The specialist committees are summarised in Appendix A (some of the committees shown have delegated responsibility to groups/committees below the level shown)..

Health and Safety Committee
The function of this committee is to maintain effective joint consultation across the Trust, monitoring (with the aid of the incident reporting system) the health, safety, welfare and environment within the workplace for staff, patients and others to the site in line with statute legislation. The accountability for the committee is to the Corporate Risk Committee.

Quality Group
Implements a quality assurance and quality improvement programmes. Assurance is achieved through a range of sources including: quality walkabouts; real time data review; spot checks; quality board report; CQC provider information requests; divisional quality board papers. This work is supported by the Trust's quality improvement programme which is overseen by the Group. Quarterly reports are provided to the Quality & Risk Committee.

6.2 Divisional responsibilities

Directors
Directors are responsible for ensuring that risk is managed appropriately in their area of responsibility. These responsibilities will in the main be discharged through the implementation of good clinical governance practices to identify and manage risk (see section 5.1 for sources of risk identification).

High (red) risk issues are to be escalated to Trust Executive Group and/or the Board.

ADOs/Deputy Directors and Clinical Directors
ADOs/Deputy Directors and Clinical Directors are responsible for ensuring that hazards are controlled appropriately in their area of responsibility. These responsibilities will in the main be discharged through the implementation through good clinical governance practices to identify hazards and manage risk (see section 5.1 for sources of risk identification). These approaches will be implemented in the services, departments and specialities in their management responsibility.

Key responsibilities include:

- Taking action on hazards identified within their area that cannot be eliminated by the Lead Clinician, Head of Department, Service Manager or Matron. This includes the development of continuity plans for key business risks (see Business Continuity Policy PP256).
- Investigate and manage serious incidents (graded as red) using the Trust's approved Incident reporting and management procedure. Ensuring that lessons are learnt and changes in practice implemented, including appropriately sharing across the Trust.
- Coordinate inquest preparation relevant to their area of responsibility.
- Review compliance with NICE and other national guidelines or standards.
- Consider and addressed issues identified through clinical benchmarking indicators and performance assessments.
- Act on risk issues escalated by Lead Clinicians, Heads of Department, Service Managers and Matrons

Escalating any significant concerns to the appropriate Director and reporting via Divisional Executive Performance Meetings to Trust Executive Group and/or Board.

Lead Clinicians, Heads of Department, Service Managers and Matrons
Lead Clinicians*, Heads of Department, Service Managers and Matrons are responsible for ensuring that risk is managed appropriately in their area(s) of responsibility.

Key responsibilities include:

- Reviewing risk assessments
- Reviewing incidents, complaints and claims within their area and identifying lessons learnt
- Identifying lessons and changes in practice arising from incidents, complaints and claims that should be shared across the Trust
- Acting on the results of audit reports and their recommendations
- Reviewing training provision and uptake (including: induction (Trust and local), mandatory training, competencies, skills and equipment)

Escalating any significant concerns to the appropriate ADOs and/or Clinical Director.

* For specialities in which a Lead Clinical has not been identified responsibilities remain with the Clinical Director.

Managers (including Ward Managers and Area Managers)
All managers are responsible for:

- Managing hazards and associated risks in their areas of responsibility. This includes for example, incident investigation, workplace inspection and undertaking risk assessment.
- In support of this responsibility for health and safety the Trust has recognised and introduced the roles of 'Health and Safety Representatives' from recognised unions, and has trained key individuals to become 'Health and Safety Link Persons' with functions similar to those of Health and Safety Representatives. Managers should ensure that they nominate someone to act in this role for their areas of responsibility. The responsibilities of the 'Health and Safety Representative/Health and Safety Link Person' are detailed in the Health, Safety and Welfare Policy PP018, and should only be undertaken by those who have received the appropriate health and safety training. **N.B the manager's accountability for health and safety cannot be delegated.**
- Undertaking risk assessments using the Trust's agreed policy and procedure within their areas to identify and assess hazards and escalate risks rated medium (amber) or more to their immediate manager.
- Must take immediate action to eliminate or reduce risks rated as high (red) or more.

- Recommend, implement and monitor the effectiveness of those appropriate control measures to eliminate or minimise the risks within their areas of responsibility.
- Ensuring that all staff and others in their areas affected by the organisations operations are made aware of all the hazards within their working environment and of their personal responsibilities, and that they receive appropriate information, instruction, training and supervision to enable them to work safely.
- Ensuring that staff within their area are aware of the Trust's strategy for managing risk, and their individual responsibilities in delivering this strategy.
- Ensuring that staff within their area are appropriately trained (see section 7).
- Escalating any significant concerns to their Head of Department, Service Manager or Matron.

All staff
All staff are expected to:

- Report incidents and near misses using the Trust's incident reporting system (Datix) and in accordance with the Trust's Incident reporting and management policy and procedure PP105
- Support safe clinical practice in diagnosis and treatment.
- Take reasonable care for the health and safety of themselves and of others who may be affected by what they do while at work
- Be familiar with the Trust's risk management strategy and departmental risk issues.
- Adhere to all relevant Trust policy and procedures.
- Be aware of emergency procedures relevant to their area of work.
- Attend mandatory training or seek additional training to carry out the duties of their role.

Divisional Performance Review Meetings
Responsible for reviewing quality, finance and operational delivery/performance within the Division. This includes:

- Receiving performance reports for the key areas, including defined metrics and KPIs
- Receiving Divisional reports detailing areas of good practice and concerns with appropriate remedial action plans
- Accountable to the Executive Directors Meeting and escalating areas of concern as appropriate to TEG and/or Board.

Divisional Board
Provides a create a single line of accountability for all aspects of quality and performance including patient safety, patient experience, quality improvement, operational standards, financial performance and staff engagement relating to the Division.

- Approve the division's **strategies, policies, plans and business cases** and allocation of management, financial and physical resources in line with the Trust's strategic framework, ambitions and operational plan
- Monitor the division's **quality, operational and financial performance**, agreeing actions and responsibilities to address shortcomings to ensure delivery of:
    - quality and performance metrics, statutory duties, national and local standards and targets and other obligations
    - quality priorities and quality improvements, including CQC self-assessment
    - activity and income plan
    - capacity and workforce plans
    - cost improvement plan to achieve the Trust plan for the division and monitor its delivery and receive assurances on project quality assurance scores
- Review divisional **business plans**, including consideration of all underpinning strategies e.g. information, estates, education, and workforce etc
- Develop and deliver **transformation schemes** for the division
- Review **capacity and demand** within the division and approve changes to use of resources in line with identified need

- Prioritise and implement capital and revenue **business cases** gathering relevant evidence of benefits realisation. Approval of business case will be made in accordance with the approved scheme of delegation
- Ensure that **risks** to patients, staff or performance are effectively identified, assessed and managed and as appropriate escalated
- In accordance with the Trust's performance management framework, ensure effective preparation for the Divisional Performance Review Meeting **escalating** issues as appropriate and reporting business case decisions taken within delegated authority.

Divisional Governance Steering Group
The divisional board is able to delegate some responsibilities to this forum which has responsibility to consider quality and risk management issues within the Division. This includes:

- Monitor and when necessary take action to improve performance against agreed Trust and division quality priorities in relation to safety, effectiveness and patient experience
- Provide a systematic approach to encourage learning and promote improvements in practice based on individual and aggregated analysis of incidents, complaints and claims, through:
    - Monthly review of incidents, complaints and PALS enquiries, including monitoring of action plans for amber incidents.
    - Regular analysis of incident and complaint data
- Reviewing identified hazards and associated risks within the division, including review of the Risk Register and remedial action taken/planned.
- Ensure effective implementation of best practice locally through audit, clinical benchmark analysis and implementation of national best practice (e.g. NICE and Royal College reports).
- Monitor and review governance arrangements within components of the division (specialties, wards or departments).
- Escalating any significant concerns to ADOs/ Deputy Directors (or equivalent)/Clinical Director to consider reescalation to the Divisional Executive Performance Meeting or TEG.

Operational, specialty & business unit meetings
To work in collaboration with colleagues within the triumvirate in achieving divisional & strategic objectives. The triumvirate is responsible for the performance of their business unit for all national and local targets and other metrics monitored and reported by the Trust. This includes the monitoring and management of:

- All quality metrics collected including all those included in the quality dashboard such as patient falls and pressure ulcers
- Patient experience performance including all patient surveys, Friends and Family testing, patient complaints and compliments
- Quality improvement framework and delivery, including audit and effectiveness
- Health and safety management including management of the business unit risk register and incidents and trends
- Management of budgets, capital spends and monitoring of project ROI
- Adherence to national and local targets e.g. 18 week RTT, Rapid Access and the 4 hour emergency attendance target
- Achievement of relevant CQUIN requirements
- Workforce metrics including sickness absence, efficiency of rostering, recruitment and retention and use of bank and agency staff
- Service reviews including skill mix and production of business cases
- Business planning, short and long term in line with the Trust's strategic framework
- Populate & analyse the business unit dashboard in liaison with the triumvirate colleagues at monthly business unit meetings
- Any business cases or plans requiring approval for the business unit, including the production and monitoring of benefits
- Implement decisions of the Divisional Board

- Report and escalate issues as appropriate to the Divisional Board.

Ward/Department Governance Groups
Have responsibility to consider quality and risk management issues within the ward/department. This includes:

- Monitor and when necessary take action to improve performance against agreed ward/department quality priorities in relation to safety, effectiveness and patient experience
- Provide a systematic approach to encourage learning and promote improvements in practice based on individual and aggregated analysis of incidents, complaints and claims, through:
    - Monthly review of incidents, complaints and PALS enquiries, including monitoring of action plans for amber incidents.
    - Regular analysis of incident and complaint data
- Reviewing identified hazards and associated risks within the area, including review of the Risk Register and remedial action taken/planned.
- Ensure effective implementation of best practice locally through audit, clinical benchmark analysis and implementation of national best practice (e.g. NICE and Royal College reports).
- Escalating any significant concerns to Service Manager/Matron and/or the Divisional Governance Steering Group.

6.3 Governance Department

Within the Governance Department, the following key posts support the management of quality and risk in the Trust: Trust Secretary & Head of Governance, Head of Patient Safety and Clinical Effectiveness, Health, Safety and Risk Manager, Complaints Manager, Information Governance and Legal Services Manager, Divisional Governance Managers, Compliance Manager and Datix Administrator. Together these posts are responsible for:

- Communicating and co-ordinating the process of risk management throughout the Trust.
- Supporting Division Governance Steering Groups to identify and manage risks at a local level.
- Acting as a central reference point for all risk management issues and co-ordinating the management of risk activities throughout the Trust.
- Managing the Trust's system (Datix) for reporting incidents and near misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health and Safety Executive, Care Quality Commission, Audit Commission, NHS England and the NHS Litigation Authority.
- Supporting the review of incident trends and feeding back information and learning to relevant committees, i.e. Clinical Safety & Effectiveness Committee and Division Governance Steering Groups.
- Co-ordinating the investigation of serious incidents in line with the Trust's Incident Reporting and Management Policy PP105, where appropriate facilitating a root cause analysis.
- Reporting of Serious Incidents Requiring Investigation (SIRIs) to the Clinical Commissioning Group (CCG) and providing progress reports regarding investigation and learning.
- Managing claims (clinical negligence, employers and public liability, property losses) quickly, economically and effectively to minimise the financial and other potential negative consequences e.g. distress to the claimant and negative publicity etc.
- Supporting the clinical audit process by promoting, supporting and facilitating this across the Trust so that that all patient care wherever possible should be evidence based.
- Ensuring that appropriate audit processes are in place and that results and recommendations coming from clinical audit are incorporated into the clinical governance agenda of divisions and are their implementation monitored.
- Co-ordinating the implementation of NICE guidance, National Service frameworks (NSFs) and Confidential Enquiries.
- Ensuring that the Trust has appropriate and adequate 'insurance' arrangements with the NHSLA Risk Management scheme in respect of clinical negligence and third party and professional liability and where appropriate commercial insurers.

- Acting as a central source of information on risk and statutory safety issues, distributing this information as necessary using the Trust's risk register and assurance framework.
- Ensuring that the Trust has appropriate policies and procedures relating to risk/health and safety issues to comply with statutory requirements and Approved Code Of Practices.
- Ensuring effective liaison with other organisations with whom there is a shared responsibility for risk management such as the CCG

6.4 Other specialist support

Specialist support and advice is also available from Occupational Health, Estates Compliance Officer, Local Security Specialist, Infection Control Team (including the Director of Infection Prevention and Control), Named Nurse for Safeguarding Children, Blood Transfusion Team and Clinical skills trainers.

7. Education and training

7.1 Board members and senior managers

The Board of Directors and Senior Managers will receive specific risk management training on an annual basis. This will be arranged by the company secretary and reflect specific learning needs of board members and issues included within the annual risk management plan.(details Appendix C) and quality improvement plan. This training will be considered mandatory and where individuals miss training alternative opportunities will be arranged.

It is essential for senior staff to have a high level of awareness of the duties placed upon them by the Health and Safety at Work etc Act 1974 and other relevant legislation.

All managers within The Trust are required to attend a managerial health, safety and risk awareness induction and to undertake the three yearly cycle of e-learning refresher training. Any change in policy / practice / legislation etc. will be addressed through targeted update training to all relevant staff.

Anyone undertaking risk assessment or who is involved with the management of risk should attend risk assessment training which will provide the necessary skills to undertake risk assessments, manage risks appropriately and to understand the Trust's processes for risk management. This training is provided by the Health, Safety and Risk Manager who can be contacted for course information and details by ringing ext: 3944. A register of training will be maintained by HR to allow reporting and monitoring.

7.2 All staff groups (including volunteers)

The policy and procedure for delivery of mandatory training to all other staff groups is set out in trust policy PP244 mandatory training.

8. Monitoring

- Annual review of the Executive Committees' terms of reference to ensure they have fulfilled their responsibilities.
- The Board receives information on key performance indicators as part of the Quality & Performance dashboard
- The Trust rolling programme of workplace assessments will identify whether appropriate risk management processes are in place at local level (e.g. local risk assessments).
- The Trust Executive Group will receive information on its high (red) risks.
- Quarterly Risk register reports to Corporate Risk Committee includes thematic analysis of the risk register
- Corporate Risk Committee review of progress with priorities set out in the risk management development plan (Appendix C).

9. Development of strategy and policy

9.1 Other relevant documents

Incident reporting and management PP105; Handling of Clinical Negligence and Personal Injury Claims PP061; Health, Safety and Welfare Policy PP018; Inquest policy and procedure PP135; Local resolution of complaints PP002; Maternity, Obstetric and Gynaecological Risk Management Strategy PP137; Occupational Health Policies PP046; Staff Concerns about Patient Care PP056; Risk assessment policy and procedure PP132, PP244 Mandatory training; Business Continuity Policy PP256, NICE policy PP218, Responding to nationally issued best clinical practice publications PP205

9.2 Changes compared to previous document

This document replaced the Trust's previous Risk Management Strategy (PP(13)093). Changes to the document include:

- Minor changes to wording to bring up to date and improve readability
- Updated details of specialist committees
- Updated KPIs within document consistent with those reviewed by Board on monthly basis
- Updated the risk matrix (section 5.3)

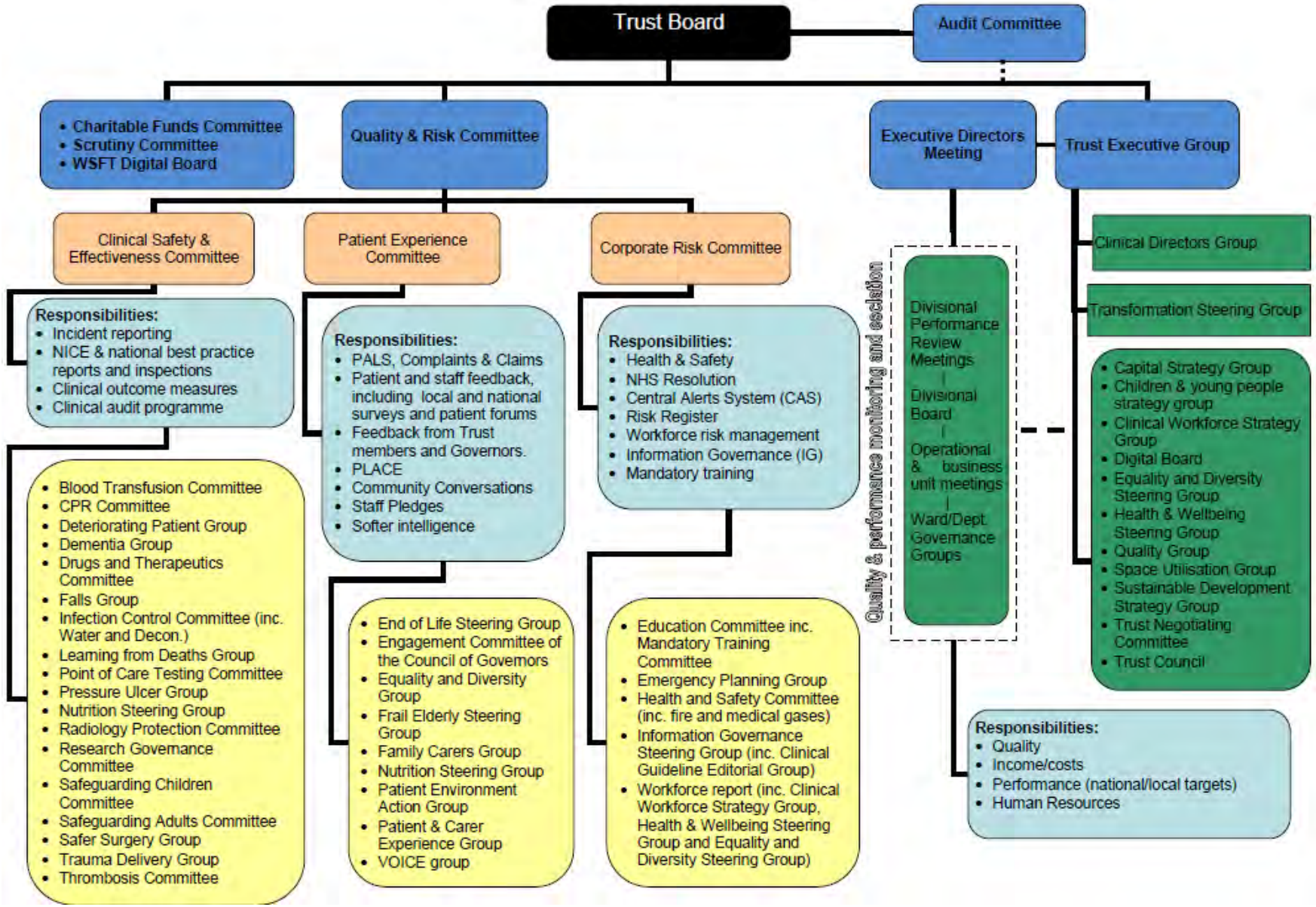
9.3 References

Health and Safety at Work etc Act 1974).
Building the assurance framework: a practical guide for NHS boards (Department of Health 2003).
NHS Litigation Authority Risk Management standards (April 2008)

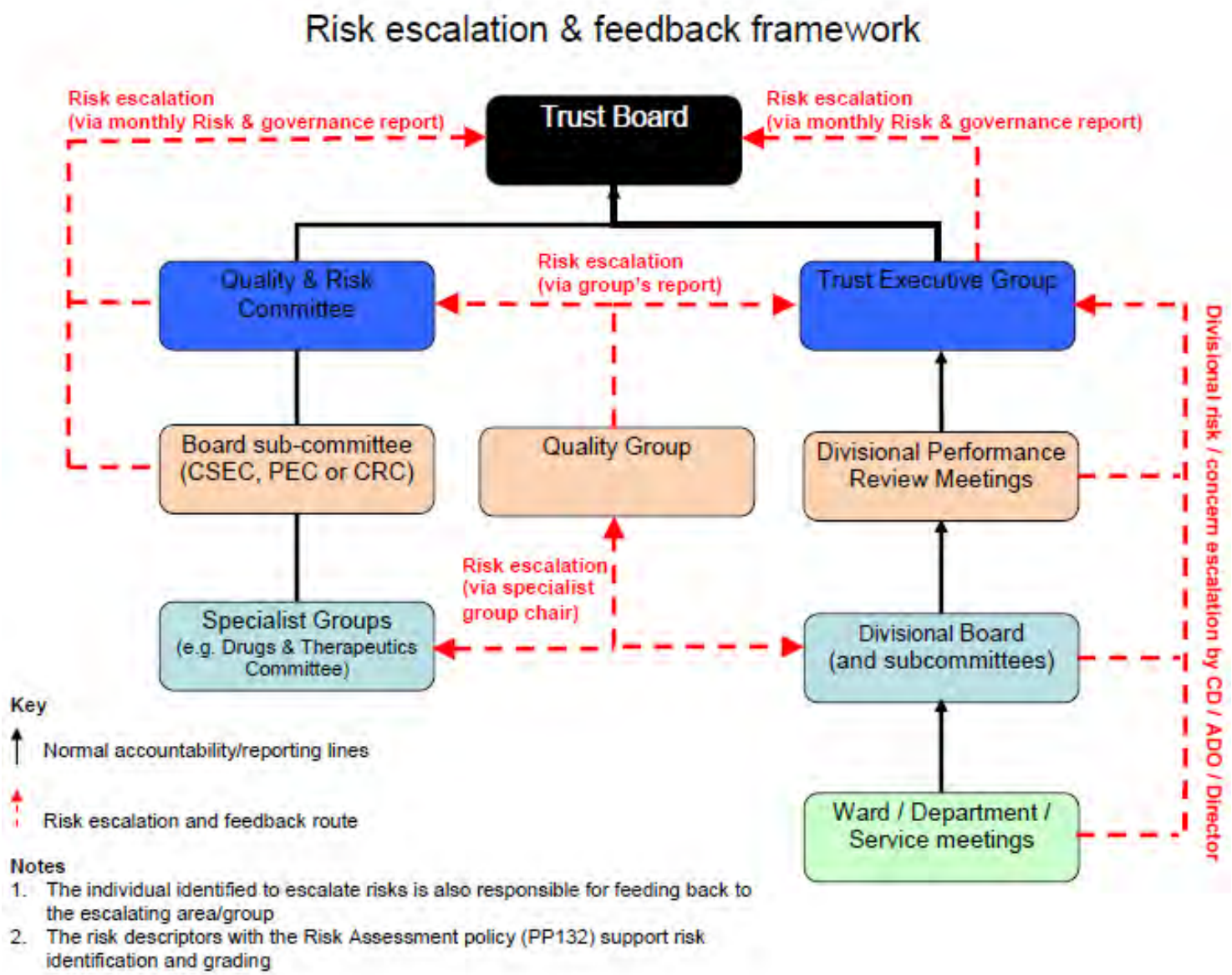
Document configuration information

Author(s):	Trust Secretary & Head of Governance
Other contributors:	Health, Safety and Risk Manager, Executive Chief Nurse
Approvals and endorsements:	Trust Executive Group, Quality & Risk Committee and Trust Board
Consultation:	
Issue no:	14
File name:	S:\Governance strategies and policies\PP(19)093 Risk Management Policy and Strategy.docx
Supersedes:	PP(17)093
Equality Assessed	Yes
Implementation	This document will be widely circulated within the Trust, including all heads of department and ward managers and will be made availability on the Trust's Intranet and Internet sites. Relevant changes will be brought to the attention of staff during circulation. Comprehensive training programmes exist including mandatory training and relevant modules as detailed in the Trust's training prospectus. Specialist training will also be targeted at those with responsibility for managing hazards with a high risk rating.
Monitoring:	See section 8. The Corporate Risk Committee has the responsibility for monitoring compliance to this policy and strategy. The committee also has the responsibility for monitoring the development plan and providing assurance to the Quality & Risk Committee on its ongoing progress.
Other relevant policies/documents & references:	See section 9.1 and 9.3

Appendix A: Governance structure for managing risk



Appendix B: Risk escalation and Feedback Framework



Appendix C: Risk management improvement priorities

The following priorities are underpinned by an improvement plan which is approved and monitored by the Corporate Risk Committee.

Area for improvement
Develop and embed the H&S framework across the Trust based on best practice policy and procedures (PLAN *)
Ensure effective understanding of H&S and risk across the Trust (DO*)
Maintain effective monitoring of H&S and risk framework (CHECK *)
Monitor key performance indicators (KPIs) for risk and health and safety and ensure lessons are learnt across the organisation (ACT *)
Ensure effective use of IT to support and maintain effective an risk management framework and communication

* Based on HSG 65 publication by the Health & Safety Executive – Plan, Do, Check and Act

20. Quality & Risk Committee report

To approve the report recommendations

For Approval

Presented by Alan Rose

Board of Directors – 26 July 2019

Agenda item:	20			
Presented by:	Alan Rose, Deputy Chair & Non-Executive Director			
Prepared by:	Ruth Williamson, PA			
Date prepared:	15 July, 2019			
Subject:	Quality & Risk Committee Report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of the Quality & Risk Committee meeting that took place on 28 June, 2019, including a summary of the subcommittees held during quarter 3.

The meeting received presentations on the Capital Nurse Programme and CQC inspection schedule (Annex).

(a) **Corporate Risk Committee (17/05/19)**
Number of outstanding fire risk assessments highlighted. A new fire officer is now in situ, with plans in place to complete all assessments by end of July, 2019.

(b) **Clinical Safety & Effectiveness Committee (10/6/19)**
Two issues flagged; CPE screening and policy/clinical guideline compliance, which have also been raised at TEG. Since the previous report on policy/guideline compliance the number outstanding had been reduced by 16%.

(c) **Patient Experience Committee (14/6/19)**
Complaints Annual Report was received and discussed. Noted a review of the recent increase in complaints to be conducted by Nick Jenkins and Rowan Procter in an attempt to identify any themes.

(d) **Quality Group report**
Report received. Terms of reference were discussed and amendments agreed.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	**X**	**X**				

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Previously considered by:	**-**
Risk and assurance:	Review and escalation of risks through governance framework
Legislation, regulatory, equality, diversity and dignity implications	-
Recommendation: To accept the report.	

QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 28 June, 2019,
Commencing at 2.00 p.m. in the Northgate Meeting Room, Quince House, WSFT

COMMITTEE MEMBER			Attendance	Apologies
Sheila Childerhouse	**(SC)**	Chair (Chair)	**X partial attendance**	
Stephen Dunn	**(SD)**	Chief Executive	**X**	
Craig Black	**(CB)**	Director of Resources		**X**
Nick Jenkins	**(NJ)**	Medical Director		**X**
Helen Beck	**(HB)**	Interim Chief Operating Officer		**X**
Jan Bloomfield	**(JBI)**	Director of Workforce & Communications		**X**
Rowan Procter	**(RP)**	Chief Nurse	**X**	
Kate Vaughton	**(KV)**	Director of Integration & Community Services		
Gary Norgate	**(GN)**	Non-Executive Director	**X**	
Richard Davies	**(RD)**	Non-Executive Director	**X**	
Richard Jones	**(RJ)**	Trust Secretary & Head of Governance	**X**	
Alan Rose	**(AR)**	Non-Executive Director INTERIM CHAIR	**X**	
Angus Eaton	**(AE)**	Non-Executive Director		**X**
Louisa Pepper	**(LP)**	Non-Executive Director	**X**	

In attendance		
Alex Baldwin	**(AB)**	Deputy Chief Operating Officer
Diane Last	**(DL)**	Clinical Education Lead - Presentation only
Florence Bevan	**(FB)**	Governor – Presentation only
Joe Pajak	**(JP)**	Governor – Presentation only
Gordon McKay	**(GM)**	Governor – Presentation only
Garry Sharp	**(GS)**	Governor – Presentation only
Peter Adler	**(PA)**	Governor – Presentation only
Robin Howe	**(RH)**	Governor – Presentation only
Jane Skinner	**(JS)**	Governor – Presentation only
Peta Cook	**(PC)**	Governor – Presentation only
Kathryn McMahon	**(KM)**	EA to Executive Director of Resources (Minutes)

Action

Capital Nurse Programme

RP introduced Diane Last, Clinical Education Lead, to the committee.

RP referred to the 'Chief Nurse' event she had attended on the 'Capital Programme', how they decided as part of workforce planning, to get together to work out recruitment and retention, training, recruitment retention and productivity, (this was in respect of attracting staff to come and work in the London area). She noted that in regard to the 'Capital Nurse Programme' overview, this was something that the Trust took as normal business practice. SD noted an important point was how the NHS badge and package certain schemes and this was a prime example of that.

Diane Last introduced the presentation. She gave an overview of all programmes the hospital currently ran. She noted that they ran Apprenticeships,

Level 2 and 3 which were taught in-house. There was also a Nursing Associate role which was in development and that they were working with local universities and developing how they would utilise that role in the best way. She noted the Assistant Practitioner role, that this had started in 2010 and was a good programme that gave a step up into nurse training. She noted that the Trust were the first organisation locally, that offered a four year apprenticeship. Diane noted that the Trust had a lot of nursing assistants that were registered nurses in other countries and that the Trust supported them both academically and financially, in order to gain their NMC Pin.

Diane noted the Care certificate, that this was in place to make sure nursing assistants were achieving a fundamental level of understanding and care. As such there was a Care Certificate policy in place, to not only meet national but local standards also.

Diane explained the training schedule for a new nursing assistant. The aim was to make sure they were on track with their work and completed a workbook which was supplied to them by the Trust; all of this took place within the first 12 weeks. She noted that once the nursing assistants were on the wards they would then be brought back for an additional study day at around 6 months, they were also offered a place on an AIMS course at 9 months. RP noted other routes that nursing assistants could take, i.e. to work as an infection control lead worker and that there were a number of end of life workers on wards.

There was a discussion around the nursing assistant uniform that they had a blue handkerchief to indicate they were on the programme, this was to ensure they didn't get asked to undertake duties that they couldn't do on their own. Diane also explained the support in place for the nursing assistants and made reference to specific staff that supported them throughout their journey at the Trust.

Diane noted how the programme had evolved and explained what changes had been made in light of comments and feedback received from participants. Diane noted that they now followed this style programme with rehab assistants, the Support To Go Home team amongst other staffing groups. She noted, in the ideal world they would like to have this extended to Housekeepers and Porters (and all patient interfacing roles).

Diane noted that originally, before the programme they were losing around 27% of nursing assistants within first 12 weeks, however, this was now down to 10%. In regard to student nurse recruitment, Diane explained that they had now expanded to 2 other universities, the University of Suffolk and Ipswich and UAE in Norwich. Following questions from committee members Diane advised that they asked for 50 students, however, they had only received 25 a year (from University of Suffolk and Ipswich). Peter Adler asked around the volume of male nurses at the Trust.

Diane noted that the 'Peer Mentorship Programme' had been recognised by the 'Nursing Times' recently, which was a fantastic acknowledgement for the Trust. In regard to the newly registered nurse recruitment, Diane noted that it was recognised that those within 1st year of qualifying are most likely to leave nursing as their first year is the toughest year, so they offered a preceptorship programme, to make sure that nurses felt supported all the way through their training and working in the Trust.

In regard to Overseas recruitment, Diane and Rowan made reference to two previous visits to the Philippines they had attended and now instead, they held regular skype interviews, which they felt were working really well. Diane noted

that Ali and now Kayleigh worked very closely with all the new Philippine nurses that came to the trust, she advised they had, to date, 45 nurses that had passed their OSCE, they advised there were 30 nurses on the programme currently and that there were 45 nurses that had already gone through the programme. RP and Diane noted the pass rate of the course was 100%. SD additionally noted the two month free accommodation that was also offered to the nurses. RP advised that they had lost some Portuguese nurses to other trusts but that, to date, they hadn't lost any of the Philippine nurses.

Diane discussed the retention details for the workforce. RP noted that the Trust was 23 over establishment by October. However, RP commented that these additional staff members built up the Trust's resilience for future planning. RP thanked Diane for all her efforts and hard work, SD echoed that. SD asked how the Trust had moved from -18 to +23; RP explained this was mainly due to the good reputation of the Trust. Diane advised the induction for September was now oversubscribed with over 30 people and that there was around 20 -25 newly registered nurses who wanted to come and work here at the Trust.

CQC Inspection Schedule

RP introduced the item. She noted the start of the CQC process. She noted the provider requests for information and the countdown for a 25 week programme. She noted they had 3 weeks to submit, by 3rd July, and once submitted CQC would look at the return and look at everything that had happened since the last inspection. She explained that the CQC used all the information put together and decide what core services they should inspect.

RP noted that if they chose to look at more than 4 core services, then the CQC had to give more details on timing of the visit in order to make room to accommodate a larger team on site. She explained the dates in mind and discussed with the committee. She also noted the timeframes for the inspection.

RP noted the preparation scheduled for each of the divisions and the reviewing process. RP discussed areas of the hospital to highlight and mentioned some coaching they could offer colleagues and teams within the hospital. She went on to explain the processes in place and importance of verbal communication with the CQC team. RP noted areas she felt would be under review, these being 'requires improvement' previously flagged areas (from 2016 report) i.e. ED, Maternity, critical care. Peta Cook asked if the CQC would come out to community, RP noted yes they would. SC asked that the slide in the CQC pack around preparation could be circulated to the committee. **RP/RW**

RJ and committee suggested speaking to COG members on the CQC inspection. Peter Adler asked who were the CQC team and what authority did they have? SD explained that the Exec team at the hospital also attended other CQC inspections and explained the array of expertise for each team on a CQC inspection.

Joe Pajak asked around a briefing for COG in the August period as there was not a Trust Board. RJ noted they were planning the briefing packs and that by end of August all would be in place. RP noted if they wanted a smaller meeting then all execs and Chair would be very happy to do this. NJ explained his thoughts and the importance for everyone to be real and say it how it actually is and that it doesn't need to be scripted feedback.

1. **Apologies for Absence**

Apologies received as detailed above.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 29 March, 2019 were accepted as a true and accurate reflection of the meeting.

3. **Matters Arising Action Sheet**

Completion of matter arising reference 49 was duly noted. There was a request in terms of making sure all underlying issues were understood in order for it to be put through TEG.

4. **Reports from Sub-Committees**

4.1 ***Corporate Risk Committee (CRC) - (17 May, 2019)***

RJ asked the committee to note the annual report and update to the TOR. All committee members approved these items.

NJ highlighted one thing on the corporate risk; he referred to board and a lot of outstanding fire risk assessments, this being due to the Trust having been between fire officers. He noted this had been discussed and the Trust now had a fire officer in place and in post and as such would anticipate that before the next meeting those outstanding fire risk assessments would be complete (all 53). It was confirmed that this was anticipated to be complete by the end of July.

4.2 ***Clinical Safety & Effectiveness Committee (CSEC) – (10 June, 2019)***

RJ noted two issues flagged for escalation around CPE screening and the second around policies and clinical guideline compliance. He noted that this same report had gone to TEG. He explained what they did was to carve up policies by area and clinical guidelines by division. In total, since that paper, at that point there were 182 out of date; however, they had reduced that by 16% in two weeks. RJ noted the positive engagement by operational areas and that there was an update going to TEG the following Monday. He noted they would be continuing to push that on but that overall response was good.

Alex noted on the work programme, page 56, stroke, this had changed, RJ noted the change. **RJ**

4.3 ***Patient Experience Committee - (PEC) – (14 June, 2019)***

AR noted PALs annual complaints report. AR asked RJ if he expected the CQC to target the complaints log, RJ noted yes this would likely be one of the data sets they would gather and look at, this would be normal practice. RJ noted they were concerned around the increase in the number of complaints; however, the Trust still had a relatively low number of complaints. RP and NJ noted they would be doing a report/deep dive for the next Trust Board in response to AR's question (around complaints). **RP/NJ**

5. **Quality Group Report**

RP provided the report. AR asked around the update of priorities as previously discussed and which RJ had previously advised of, which were three quality priorities that would be updated in Q1. RJ advised this would come via the Quality Group to Quality and Risk but would go direct to Trust Board.

RJ noted the updated Terms of Reference. AR advised that the chart on page 6 was very useful in order to see how all fed in.

There was a question raised around Item 2.2 – and it was asked whether the deputy medical director was responsible for patient safety. In answer to the question, RJ noted they could change the TOR to reflect that attendees could be added when required. SD asked around a previous discussion on a CD attending the meeting. NJ advised that CSEC had been moved to a Monday in order to accommodate CD' attendance to the meeting (around their clinical duties). AR asked that Paragraph 1.7 and 2.2 be reworded. RJ advised that instead he would add a 2.5, for COG to attend presentations. **RJ**

6. **Any Other Business**

No further items of business were noted.

7. **Reflection on Meeting and Identify Any Issues for Escalation or Capture/Review on the Risk Register**

No reflections or items for escalation were noted.

8. **Date and Time of Next Meeting**

Please note the meeting will start at 14:00 in the Northgate Meeting Room, Quince House, WSFT.

27 September, 2019
13 December, 2019

The meeting closed at 3.55 p.m.

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CQC Preparedness

Rowan Procter, Executive Chief Nurse

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The Inspection Process

Action	Week	Date
PIR received	0	12th June
PIR response	1 to 3 week	3rd July
CQC review and agree to services to review and PMR	4 - 10 week	upto 19th August
Well led dates received and unannounced will take place	11 - 20 week	26th August – 28th October
Draft report collated	21 - 24 week	4th Nov – 25th Nov
WSFT receive draft	week 25	2nd December

The preparation

Action	Status
Divisional self-assessments, with action plans.	In progress All have been reported to the quality group except Gynaecology, Outpatients and Diagnostic Imaging
Divisional preparedness reporting to PRM	In progress PRM slides to include CQC preparedness, key challenges, review of previous reports to provide assurance issues highlighted have been addressed
Executive led preparedness of high risk areas (risk based on likelihood of a visit)	In progress Executive leads for ED, Maternity, Critical Care and Community
Celebrate and communicate Excellence	In progress Divisional challenge to ensure staff at all levels are able to show awareness of local areas of excellence and confidently communicate achievements to the CQC assessor
Development of Trust's quality priorities for 2019-20 (QI, Human Factors and Patient Flow)	Complete First Qtr reports for all three reported to TEG or Quality Group
Development of Trust's quality strategy	In progress Elements being brought together include: divisional governance handbooks, QI framework, Patient Experience strategy, Patient Safety & learning strategy and others
CQC Communication strategy	In progress Elements being brought together include: CQC staff booklet, CEO staff briefing sessions, 'Key topic challenges' on intranet, and others
Policies and Clinical guidelines	In progress Overseen by TEG, Trust policies (PP documents) and Clinical guidelines (CG documents) to be updated and re-issued with an aim of no out of date documents at time of visit. Project to ensure community harmonisation (policies, clinical guidelines and SOPs) also ongoing
Well-led assessment	In planning stage (will draw on previous assessments)
Use of Resources assessment	In planning stage NB: The CQC have not YET highlighted UoR as a requirement however it is likely to form part of a Well-led assessment

21. Annual report and accounts

To receive the report

For Report

Presented by Richard Jones

Board of Directors – 26 July 2019

Agenda item:	21			
Presented by:	Richard Jones, Trust Secretary			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	19 July 2019			
Subject:	Annual report and accounts 2018/19			
Purpose:	X	For information		For approval

Executive summary

The Board is asked to receive the annual report and accounts in public session.

The report was approved by the Board in closed session in May but could not be reported publically until it has been laid before Parliament – this took place on 4 July 2019.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X

Previously considered by:	Board of Directors Audit Committee Council of Governors – for Governors commentary within Quality Report
Risk and assurance:	Failure to comply with regulatory annual reporting manual
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

The Board to receive the annual report and accounts in public session.

NHS
West Suffolk
NHS Foundation Trust

Annual report and accounts

2018/19

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West Suffolk NHS Foundation Trust

Annual Report and Accounts 2018/19

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

Contents

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

1. Performance report

1.1 Overview

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

1.1.1 A message from the chair and chief executive

In the year the NHS turned 70 years old we have certainly given the people of west Suffolk much to celebrate when it comes to local healthcare.

At the start of last year we got the public recognition and celebration our staff deserve in the form of our outstanding rating from the Care Quality Commission. We remain a high performer, and have indeed been classed as “the best small hospital in the country” by the Health Service Journal (HSJ), and that’s something of which we should be very proud.

Across the year we have had much to celebrate. We built and opened the first part of our new acute assessment unit (AAU), opened a new urology diagnostic unit, launched new community services like ultrasound and X-ray clinics, and enhanced the range of clinical procedures we offer our cardiac patients with the build of our fantastic new cardiac suite.

We added to our clinical accolades with some exceptional results in hip fracture care and cancer survival rates (west Suffolk has some of the best cancer survival rates in the country), saw our volunteers go from strength to strength, and made some great digital advances; we were the first in the country to link our electronic patient record system with another trust through our work with Cambridge University Hospitals NHS Foundation Trust, and we embarked on our new digital communication channel, Medic Bleep.

Through it all our hospital and community staff have continued to tell us that they like working here – we remain high scorers in the NHS Staff Survey for staff engagement, ranked as the best in the East of England and the fourth best in the country by the HSJ. Our staff wellbeing and happiness at work really does matter to us, and this needs to continue.

Of course it’s not all been plain sailing, as life in the NHS rarely is; our staff have been under significant pressure over the last 12 months. Demand for our services has increased again, as has the number of people needing to be admitted to hospital. Despite being more prepared than ever before we were still stretched across the winter, and needed to open more escalation beds than we had hoped.

We often had to move colleagues from one ward to another in order to ensure that we had enough staff to run a ward at a level we consider safe. Whilst we are actively recruiting and have more nurses than ever before, we know we still need more people on the ground and that the NHS nationally is struggling with this same challenge.

You will find more information in this report about our challenges in meeting some of the national standards, including the four-hour emergency access measure. We’ve generally performed admirably given the increase in the number of patients we’ve seen, but we’ve still found it difficult to meet the 95% standard amongst others.

But it is down to our staff that we are able, overall, to reflect positively on a fantastic year. Their sheer hard work and determination to give every patient the best quality care is exceptional, and we remain incredibly grateful for everything they do for the Trust, and the west Suffolk community.

Sheila Childerhouse
Chair
28 May 2019

Dr Stephen Dunn
Chief executive
28 May 2019

1.1.2 About our Trust – a summary

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

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

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 community

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

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

The challenge for WSFT is clear: we must stay ahead on the quality agenda, we must maintain strong operational performance, and we must secure financial sustainability and improve the facilities we work in.

Our priorities are:

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

Our **seven ambitions** take a holistic approach to the care of our patients. These ambitions focus on the reason we all get out of bed in the morning and work in the NHS: to serve our patients and work with them and the public to deliver year-on-year improvements in care.

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

patients, their families and carers. Working with partners will be important in achieving these ambitions across a diverse population with differing needs.

We want to make sure every child is given the best start by promoting a healthy pregnancy, natural childbirth and breastfeeding. Staff are encouraged to use the contact they have with patients to offer appropriate advice on staying healthy, placing a greater focus on the prevention of poor health, not just treating it.

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

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

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 go home on the same day. WSH has around 500 beds and 14 operating theatres, including three in day surgery and two in the eye treatment centre. Access to specialist services is offered to local residents by WSFT networking with tertiary (specialist) centres, most notably Addenbrooke's and Papworth hospitals. 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 service, working with community therapists and a community neurological nurse specialist. We have taken on responsibility for Newmarket Hospital, a community hospital in Suffolk with approximately 20 beds. These 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 Hospital as a base.

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

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

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

The Trust is also responsible for, via a contract with the East and West Suffolk clinical commissioning groups, the provision of adult community healthcare teams, adult speech 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 shared services for lymphoedema and an integrated pain service with the Suffolk GP Federation.

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 4,045 staff as of April 2019.

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

Our partners

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

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

Going concern

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. In addition, the Trust has a borrowing arrangement in place with the Department of Health (DH) to support its liquidity position. If the Trust no longer existed health services funded by the DH would still be provided. For this reason, the directors continue to adopt the going concern basis in preparing the accounts.

The Trust is in deficit because its costs exceed income. The Trust has outstanding loans from the DH totalling £87.4 million at 31 March 2019 (£62.8 million at 31 March 2018) for capital investment, working capital and revenue support. In addition, the Trust has £2.8 million loans outstanding from a commercial loan provider for capital investment (£2.4 million at 31 March 2018). These figures exclude borrowing associated with finance leases.

The Trust plans to break-even in 2019/20, principally through additional funding provided to acute providers to recognise historic underfunding totalling £12.5 million and also by implementing an £8.9 million cost improvement programme.

All liabilities are ultimately underwritten by the DH as confirmed by statute therefore the Trust accounts are prepared on a going concern basis.

1.2 Performance analysis

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

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

1.2.1 Performance management framework

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

Performance monitoring:

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

Governance framework:

- Assurances provided through the work of the clinical safety and effectiveness committee, corporate risk committee and patient experience committee
- Reports from the quality and risk committee, scrutiny committee and the audit committee received by the Board
- Self-assessment against delivery of the Care Quality Commission (CQC) registration requirements
- Assurances provided through the work of internal and external audit, the CQC, NHS Improvement, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the Council of Governors.

Engagement and measurement:

- Weekly quality walkabouts, including executive directors, non-executive directors and governors
- External regulatory and assessment body inspections and reviews, including royal colleges, post-graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports
- Benchmarking for clinical indicators
- The work of clinical audit, which within its scope includes national audits, audits arising from national guidance such as 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 identified concerns or enforcement action.

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

Our services

We provide a range of patient services:

Indicators	2018/19	2017/18	2016/17	2015/16	2014/15
Inpatient planned	**3,548**	3,730	3,917	4,291	4,290
Inpatient non-planned	**32,832**	32,505	33,174	31,383	30,173
Day cases	**31,696**	30,824	30,105	29,392	28,210
Outpatient attendances (inc. ward attenders)	**266,157**	249,460	239,413	239,675	228,384
Outpatient procedures	**79,404**	82,880	87,474	106,032	161,317
Emergency department attendances	**74,400**	70,918	67,176	64,979	62,106

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

In 2018/19 our community teams in the west of Suffolk have had 52,000 new referrals, more than 200,000 face-to-face patient contacts, 38,000 telephone contacts and delivered almost 15,000 pieces of equipment.

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

Our financial performance

We recorded a deficit of £11.6 million for the year 2018/19. However, our planned control total was £13.8 million before receipt of provider sustainability funding (PSF), impairments and the effect of donated assets. Our deficit would have been £13.5 million before PSF (£7.0 million) impairments (£5.5 million) and the net effect of donated assets (£0.4 million) which is £0.3 million better than our control total.

	2018/19 £000s	2017/18 £000s	2016/17 £000s	20115/16 £000s	2014/15 £000s
Operating income	**244,952**	252,778	254,933	209,588	172,589
Operating costs	**(242,770)**	(245,906)	(251,016)	(213,994)	(171,998)
EBITDA * surplus/(deficit)	**2,182**	6,872	3,917	(4,406)	591
Depreciation, dividend and other costs	**(8,226)**	(7,159)	(6,961)	(5,861)	(7,075)
Fixed asset impairments**	**(5,506)**	0	(4,815)	(410)	1,062
Retained earnings	**(11,550)**	(287)	(7,859)	(10,677)	(5,422)

* 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.

Note - On 1 October 2015, WSFT began providing community services in Suffolk which increased income and expenditure by around £63m in a full year. From 1 October 2017, Ipswich Hospital NHS Trust (now the East Suffolk and North East Essex NHS Foundation Trust) began providing community services in the east of Suffolk, which decreased income and expenditure at WSFT by around £18m between 2017/18 and 2018/19.

1.2.3 Principal risks and uncertainties

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

Board assurance framework (BAF)

The BAF was regularly reviewed during 2018/19 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 within the annual governance statement (section 2.5).

Incident reporting

The Trust's web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting of near misses, no harm and minor harm incidents. Reporting of these 'green' incidents is seen as a key driver for identification and management of risks to prevent more serious harm. The Board reviews this data on a monthly basis and recognises an increased incident reporting rate as a positive reflection of an open culture within the organisation which supports learning. During 2018/19, a total of 6,650 patient safety incidents were reported (compared with 6,513 in 2017/18).

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

Effective risk and performance management

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

Performance and quality improvement is connected from 'board to ward' - this is achieved through two-way communication between the Board and operational areas (e.g. wards) across WSFT. The monthly quality and performance report to the Board provides both an organisational and ward-level dashboard. This information is underpinned and informed by reviews from divisions and wards, with action-planning at these levels. Delivery of improvement at an operational level is managed through directorate executive quality and performance meetings, but is also tested through observational visits by Board members and governors as part of weekly quality walkabouts. A programme of internal peer assessment also supports continuous quality improvement against CQC standards. A programme of presentations and patient stories relating to the quality priorities and strategic/service developments is also delivered to the Board and its subcommittees. The Trust actively engages with its foundation trust membership and the public through regular talks, events and communications.

The Trust is a member of the NHS Resolution's Clinical Negligence Scheme for Trusts (NHSR CNST).

Mandatory service risk

The Trust's Board of directors was satisfied that:

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

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

Risk of any other non-compliance with licence

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

Contractors and suppliers

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 following a successful bid. During the year we, along with three other procurement partners, were successful in bidding for the contract to deliver three of the Department of Health's eleven procurement towers. This new organisation is equally owned by the four partner organisations.

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

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

Additional disclosures required by the financial reporting manual (FReM)

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

- Chief executive's responsibilities certificate (section 2.5)
- Accounting policy note 1 (part of accounts).

The accounting policies for pensions and other retirement benefits are set out in note 1 to the accounts, and details of senior employees' remuneration can be found in section 2.7 (remuneration report).

Audit committee's review of the annual report and accounts

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

An award-winning hospital

The following section outlines our many achievements during 2018/19.

It has been an impressive year for the Trust, with many accolades to be proud of.

- Finalist in the Health Service Journal Awards 2018 'Using Technology to Improve Efficiency' category, for our work in piloting new digital communications tool, Medic Bleep

- Finalist in the Student Nursing Times Awards 2019 'Student Placement of the Year: Hospital' category, in recognition of our nursing student support programme

- Rated by our staff as the best general acute in the country for giving them control and choice over how they do their work in the latest NHS staff survey (2018)

- Rated as the top hospital in England, Wales and Northern Ireland for meeting best practice criteria for hip fracture treatment by the National Hip Fracture Database

- Chief executive Dr Steven Dunn awarded a CBE for services to health and patient safety in the prestigious Queen's New Year Honours list

- Fifty women across the Trust announced as 'inspirational women of west Suffolk' as part of NHS 70th birthday celebrations

- Scored top in the East of England for doctors' overall training satisfaction in acute trusts, in the General Medical Council's national training survey (2018)

- Named as one of the CHKS Top Hospitals Award Winner for 2018

- Hannah Sharland, estates and facilities project manager, was awarded the individual development award at the Health Estates and Facilities Management Association (HefmA) awards

- Our My WiSH Charity was chosen as the regional winner in the Patient and Public Involvement Award category of the NHS70 Parliamentary Awards.

These accolades go hand-in-hand with some of our ongoing **developments and achievements** across the past 12 months. As a snapshot:

- Delivery of a £5.2m cardiac suite that allows us to deliver procedures like angiography and pacemaker fitting on site for the first time

- Opening of a new acute assessment unit (AAU) that has transformed how we assess and treat our emergency patients

- Introducing Medic Bleep, a digital app to replace physical bleeps, that has been evidenced to save valuable staff time (average 48-minutes per shift for junior doctors and 21-minutes per shift for nurses) so they can spend more of it caring for patients

- Linking our electronic patient care record in the emergency department with Cambridge University Hospitals NHS Foundation Trust, so that clinicians at either site can access information on a patient's record held by either trust

- Helping the West Suffolk Clinical Commissioning Group area to achieve the fewest excess bed days in the country (the term used to describe where people are still in hospital when they no longer need to be there).

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

Social, community, anti-bribery and human rights issues

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

The Trust has applied policies during the financial year for:

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

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

Our modern slavery statement is published on our website and outlines the approach we've 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

In September 2018, the chief operating officer, as accountable emergency officer reported to NHS England and the CCG that the Trust had substantial compliance with core standards; the Trust has implemented a substantial, innovative and dynamic review and upgrade of EPRR and the Trust has an identified lead non-executive director for EPRR.

The substantial compliance level indicated that the Trust had a number of core standards to which improvement work was required in the area of updating business continuity plans, and the provision of

the documentation for formalised training for command and control staff; it should be noted that the delivery of EU Exit planning has caused the work to be delayed.

1.2.4 Future business plans

1.2.4.1 Sustainability and transformation partnership (STP)

The Suffolk and North East Essex Sustainability and Transformation Partnership (STP) Board has been in place since early 2017. During 2018-19 local leaders within the STP agreed specific local priorities and deliverables, including the development of a small number of agreed, articulated and measurable 'higher ambitions' for the partnership. These are as follows:

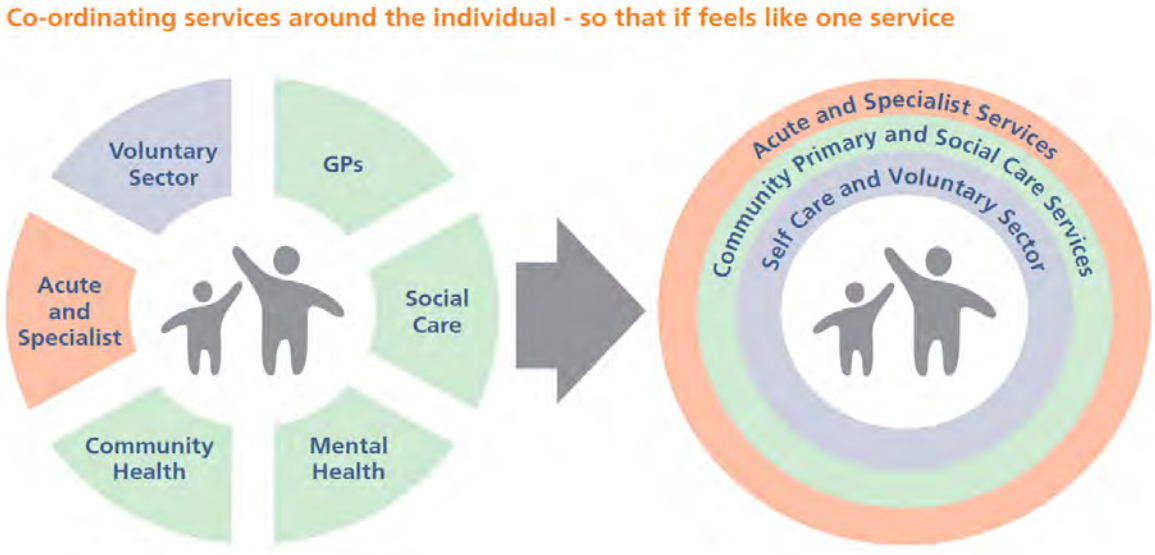
- Reducing the burden of deprivation
- Improving mental health and reducing suicides
- Being more proactive in relation to obesity prevention and treatment
- A reduction in unplanned cancer admissions
- Improved end of life care
- Neighbourhood action to combat loneliness.

In May 2018 the STP was successful in its application to become one of the 14 sites nationally to join the national system transformation programme at NHS England as a shadow integrated care system (ICS). This has allowed access to support from national teams as well as additional funding for 2019/20 to develop primary care networks and the voluntary and third sector providers at a locality/neighbourhood level.

The health and care partnership, which makes up the West Suffolk Alliance began to deliver community services within our geographical footprint in October 2017 and has been more broadly working together to improve the service offer to the population of West Suffolk since this point.

Along with the other alliances within the STP, West Suffolk was asked to produce a strategy; delivery of this is a critical element of the wider STP plan as it provides the detail on the local delivery model and the development of a new way of working in partnership at a locality level.

Our focus within the West Suffolk Alliance is on people and places, and the strategy sets out the commitment of all partners to move from working as individual organisations towards being a fully integrated, single system based around the individual. To achieve this shared vision, clear local priorities have been agreed to provide an improved service for people in West Suffolk and to tackle the sustainability issues faced by the system together.



The strategy was co-developed by all key partners and reflected the feedback previously given by patients, the public and people who use our services.

The West Suffolk Alliance has agreed four interrelated ambitions, which underpin the strategy; these demonstrate how as Alliance partners we will make progress together. They do not displace the individual organisational priorities, but rather show the benefit from Alliance working.

The Alliance strategy builds on the six Connect localities, which are arranged around natural communities, with the aim of building resilience and strengthening local services offered wherever possible. For the west of Suffolk the localities are: Newmarket, Haverhill, Sudbury, Brandon and Mildenhall, Bury Town and Bury Rural. These groupings can be thought of as a 'hub and spoke' with the system leadership as the 'hub' and the six locality areas as the 'spokes'.

Each locality has a neighbourhood team consisting of health and social care teams that work together to provide a person centred, holistic care offer supported by the wider district and voluntary sector. In addition to this, Alliance partners have mapped additional capacity to all localities, with senior leadership now in place for each. The local authority has funded a dedicated locality co-ordinator post for each area, to provide the necessary administrative support to the whole team.

The locality delivery groups (LDG) have begun to pull together their agreed priorities and these will underpin a more detailed development plan for each. A joint needs assessment is being created for each locality, which will underpin the plan and provide the performance baseline to measure outcomes against going forward. Public Health is leading this piece of work with assistance from the wider system.

The system executive group (SEG) has now been in operation for 12 months with the Alliance Steering Group supporting the delivery of the strategy. The role of SEG is to act as a system-wide discussion and shared decision-making forum, whose members are partners in the Alliance, West Suffolk Clinical Commissioning Group (WSCCG) and other key system leaders across the west of Suffolk. In June 2018, the WSCCG also agreed to use the SEG as the vehicle to sign off any CCG transformation funding to ensure that the Alliance was leading this process on behalf of the wider system.

Delivering our vision

During 2018, the Alliance strengthened and embedded integrated working across the west Suffolk system. This was primarily through the mobilisation of the new community contract but also included exploring new partnerships across the system for the benefit of the population.

Below are some examples of the impact this has had in terms of improving services for our population:

- The integration of WSFT and GP pain services to create a single service and support offer for patients
- Putting joint plans in place from community health and social work teams, allowing the locality team to operate from a single plan for a patient
- 'Discharge to optimise and assess' has been implemented across the system, which has shown a real flexibility around sharing the mission to get people home and recovering as soon as possible
- Implementation of support to go home service
- Further development of the early intervention team (EIT) to include social care and paramedic capacity to widen the scope of practice. The EIT continues to respond to people in crisis and avoided over 400 emergency admissions between April and November 2018
- Over winter, WSCCG invested in a rapid intervention vehicle through the ambulance service that works alongside EIT. In four months the vehicle response prevented 127 ambulance dispatches, of which 89 were not conveyed to hospital. An additional 137 referrals were jointly managed by both services at home away from a hospital admission
- Reduction in delayed transfers to care through moving to a joined-up, team response to safe discharge

- Integrated and rotational posts in place for acute and community nursing and therapy teams
- All therapists within the west Suffolk footprint are now managed as one team, facilitating extended roles and rotational posts
- Test and learn site for the Buurtzorg model implemented and reviewed by The King's Fund to inform proposed locality model going forward
- The development of a system primary care team working across acute and primary care rather than being based solely within the WSCCG
- The establishment of a clinical education programme, and further work towards the one clinical community model
- Engaged with over 60 staff across west Suffolk on the development of the new responsive care service offer
- Agreement to create a west Suffolk estates team
- Capital grants received for the development of Newmarket Hospital and the emergency department within WSH.

Performance improvements and efficiency savings

During 2018-19 we have continued to operate a **joint transformation team** with West Suffolk CCG to support delivery of a comprehensive programme of efficiency and improvement work covering:

- hospital
- system-wide integrated care
- system-wide planned care.

Examples from these programmes are set out below and these will be reviewed and developed to take into account the planning assumptions and key deliverables from the **NHS Long Term Plan**.

The Trust's **programme management office (PMO)** has also supported the Trust's cost improvement programme (CIP) and specific projects, delivering the targeted financial savings.

The **hospital transformation programme** is closely aligned to the system-wide integrated care programme and focuses on supporting patient flow and reducing length of stay:

- **Red to Green (R2G) / SAFER** – ensures timely patient review and escalation to support patient flow. The patient flow team support the escalation of barriers to discharge supported by nominated divisional managers of the day. Executive attendance at board rounds is now targeted at areas of concern as agreed at executive meetings. Next steps include inclusion of the patient flow team in the R2G process; particularly the identification of the golden patient who will be discharged or moved to the discharge waiting area by 10:00 am the following day. A to-take-out (TTO) medication internal professional standard was recently launched, to support timely TTO writing and discharges earlier in the day
- **Multi agency discharge event (MADE)** - following successful MADEs in October 2018 and January 2019, the use of these multiagency events will continue to ensure timely support to the hospital to prepare for and recover from periods of peak activity. During 2018/19 we had excellent support from CCG and social care colleagues which showcased how we work together. Evidence shows that running a MADE gives positive benefits: to patients, by ensuring care is delivered in the right place; to acute staff who gain a greater understanding of services available outside of an acute organisation; and to wider system partners who get a flavour of the demands faced
- **Diagnostic virtual ward (DVW)** - transformation funding has been agreed to test a DVW. The concept allows patients who are medically stable to be discharged from hospital and return for planned urgent investigations within 24-48 hours. The service runs from the discharge waiting area and currently the patient cohort consists of: cardiology for echocardiogram patients; gastroenterology for scoping patients; and surgical patients waiting for ultrasound and CT scan

- **Community delayed transfer of care (DTOC)** - working with the discharge team to ensure all three community assessment bed sites follow national guidelines with regard to DTOC reporting
- **Trustmarque** - an external consultant was engaged to work with us during October and November to conduct a data exploration exercise using our emergency department (ED) data. The project uses three years' worth of ED data which allows the ED team to drill into the data to identify trends. From this, changes can be implemented to make improvements. The model remains connected to our data allowing us to continue to drill further into any area of interest to better understand the demand in ED. We can also use it to measure the impact of 'test and learn' changes which allow small changes to be made quickly, measured quickly and either implemented fully or reverted back if no impact is achieved
- **High impact users** - WSFT will host a CCG project manager post for one year to lead on high impact users across the health and care system. This aims to undertake a programme of work focused around our high impact users of services to understand their needs and develop improved pathways of care
- **Medical e-rostering** – we have been implementing a medical rostering system called Allocate over the past year. The eJobPlan module is now live for the 2019/20 job planning round. The e-Appraisal build is also complete. The implementation of the medical rostering modules for junior doctors will be complete mid-2019 with consultants following
- **Operating theatres** – the Trust is reviewing operating theatre utilisation to increase productivity within operating theatres, measured primarily by increasing the number of cases per theatre. In addition to this, the recommissioning of a operating theatre will be undertaken during 2019 to increase overall theatre capacity in line with elective demand growth
- **Outpatients** - the outpatient steering group is leading on a range of initiatives that will realise cost savings through increased efficiency, leading to greater productivity in outpatients' services. The initiatives include a greater focus on data, optimising capacity a review of the booking process underpinned by technology, and review of the access policy. Clinic slot utilisation and clinic templates are the biggest areas for efficiency savings. In addition to this a series of system-wide outpatient workshops are planned to develop and deliver an overarching outpatient transformation strategy in line with the NHS Long Term Plan ambitions.

Despite the efficiency savings and additional capacity opened, the increases in activity we have experienced in 2018-19 have placed significant pressures on the system - emergency department (ED) attendances increased by 11.2% and emergency admissions by 9.7%. This significant increase in activity impacted on delivery of the ED performance standard, although unlike 2017/18 we did not repurpose our protected elective ward to accommodate emergency demand. Capacity **plans for winter 2019-20** include:

- Completion of phase two of the acute admission unit (AAU) build by July 2019
- Ongoing UK and overseas recruitment programme to ensure appropriate nurse staffing. This will be supported by our new staff accommodation
- Review of ED demand by hour and day of the week to establish the medical staffing requirements to support ongoing increased levels of activity
- Continuing to work with system partners on schemes for demand management and to reduce discharge delays. This includes strengthening our community focus with integrated neighbourhood teams along with greater integration of specialist acute and community teams, e.g. therapies, COPD and paediatrics.

Reviewing our model for delivery of GP streaming with the GP Federation to achieve greater integration with the wider ED team and increased throughput of appropriate patients through the service to maximise available capacity.

The **integrated care programme** is proactive, looking at avoiding unnecessary admissions to hospital, and reactive, looking at maximising patient flow and avoiding delays. Initiatives include:

- **Integrated urgent care (IUC)** – the IUC service and clinical assessment service (CAS) was launched in 2018 and focused on increased clinical triage and therefore reducing ambulance and ED calls
- **Buurtzorg** - the West Suffolk Alliance partners have committed their support to extending the pilot phase to cover Bury Town and have appointed a dedicated project nurse to oversee implementation. A workshop to consider The King's Fund review of the implementation is being planned to ensure learning can be extended to the development of the integrated neighbourhood teams
- **Rapid intervention vehicle (RIV)** - this service has been operational Monday to Friday across three localities since November 2018 and extended to weekend working at the beginning of December 2018. The vehicle is staffed by a specialist paramedic or emergency care practitioner and an early intervention team (EIT) therapist, and responds to ambulance service and EIT calls. Key activity includes falls, urinary tract infections, shortness of breath and chronic obstructive airways disease (COPD) exacerbations. Evaluation of the service is planned to inform future provision and development
- **Connect localities** - the transformation team has now aligned to each West Suffolk Connect locality working with county council, St Edmundsbury and the community leads to form a core locality delivery team. The integrated care programme is now split across all six localities with Mildenhall and Haverhill being forerunners to shape a locality based plan
- **Responsive Care** - as part of Suffolk County Council's home care re-development work, system partners are co-designing services to provide: an urgent response irrespective of health or care need; and an integrated reablement/rehabilitation response to support people at home. This might be after a fall, a stay in hospital or a period of illness and the person needs to recover functionality or be taught to adapt to a new condition. The services being considered as part of this integrated offer include the early intervention team (EIT), support to go home and Homefirst. This may also include some elements of adult social care and domiciliary care. The new service will be operational from September 2019 and will be integrated into the locality based delivery teams as much as possible
- **Discharge to optimise and assess (D2OA)** - Pathway one is now available to six base wards and is working well. The teams support two to three referrals a day and this will be expected to increase as more wards join, confidence in the referral pathway matures and community and acute occupational therapists (OTs) integrate to share the responsibility of assessment. The delivery of the model is demonstrating strong integrated working and collaboration across health and care and is an excellent example of how practitioners cut through traditional ways of working to flex delivery to the needs of individuals. An evaluation with case studies is being developed
- **Stranded patients review** – In line with the national focus on reducing the number of long stay patients in acute hospital beds, we have developed a robust process led by the executive chief nurse. Daily multidisciplinary team (MDT) reviews take place using the e-Care electronic patient record to identify delays in patient care pathways and barriers to discharge, and assess reasons for delay for inpatients that have been in hospital for seven days or more
- **Integrated respiratory service** - work on developing this service is progressing well. The physiotherapy role has been integrated with the respiratory nurses who are now referring most patients for at least one physio consultation while under their care. This physio element is a new additional service offer made possible now that both acute and community teams are working as one team
- **Paediatric physiotherapy joint working** - the acute and community based services have been exploring opportunities for integration, and have initiated changes to the way they work that are having a direct benefit for children, their families and staff
- **Vertical integration with primary care –** we are working with practices within the west of Suffolk with a view to closer working with the hospital in line with the Wolverhampton vertical integration model. We have already recognised that hospital and community services needs closer alignment with primary care and that if this can be achieved the

benefits to patients could be significant. It also provides an improved offer to support general practice to meet the rising complex demands of primary care
- **Mental health and emotional wellbeing transformation –** we are working with system partners to support this transformation programme, including consideration of a local model for the delivery of services.

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

- **100 day challenge** - this national programme is designed for primary and secondary care to jointly test ways of improving patient experience and speeding up access to elective care; it will focus on three areas: rethinking referrals, shared decision making and transforming outpatients. There are two programmes underway using this methodology. A video conferencing pilot for follow-up consultations went live in November 2018 with a small number of patients in the dietetics department. It was well received by both staff and patients. The gestational diabetes team are planning to join the pilot too. A review of the low priority procedures programme is in the final planning stages. There will be an initial roll out of the revised process in five specialties with the remainder coming on board once the initial phase is embedded
- **Right care programme** – 'RightCare' is about the whole health system taking an evidence-based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. Going forward, RightCare will be working more closely with the getting it right first time (GIRFT) team to ensure that the two programmes are aligned and no opportunities are missed. Revised and updated plans for cardiovascular disease (CVD), respiratory, gastroenterology and neurology in September 2018, have now received feedback and actions are being taken as appropriate. For CVD, neurology and gastroenterology the Rightcare work will be encompassed in the wider elective care transformation programme. Respiratory Rightcare will move to the Integrated care team
- **Treatment and care funding – diabetes management** – this NHS England led programme aims to help improve the outcomes of patients with diabetes in two key areas. During 2018 the CCG received an 'outstanding' rating assessment from NHSE for the Diabetes service in West Suffolk. This is credit to the huge amount of work that has been done by the CCG and WSFT over the past two years. Work continues to promote the structured education services and to encourage the uptake of mentor clinics at GP practices using the expertise from WSFT
- **Integrated pain management service (IPMS)** - in west Suffolk, pain management is currently provided by two providers - Suffolk GP Federation and West Suffolk Hospital. Following a most capable provider process run by the CCG, an integrated pain management service has been developed by the two providers and will remove duplication and streamline existing pathways to seamlessly provide a range of education, therapeutic and medical services for patients suffering from acute and persistent pain. The transition plans have been completed and the service went live in April 2019
- **Ophthalmology** – we continue to work with the CCG to change the delivery system of eye care services, to enable a sustainable and affordable clinical model for the growing elderly population of Suffolk. It aims to integrate eye services for the patient through a strategic partnership model of care, where the consultants can direct where work should appropriately be undertaken and the clinical skill level required in the community
- **Stroke** - a baseline review has been undertaken and a wider review is now starting across the STP. The aim is to enhance what we already have, and to future-proof stroke services as opposed to major reconfiguration. The stroke service continues to be discussed and reviewed both locally and across the STP: a review is pending to consider the hyper-acute stroke units and acute stroke units and the CCG are working on the scope for the options appraisal as well as the considerations that west Suffolk would like included in the review. Progress within atrial fibrillation detection, prevention, perfection and correction continue. There is sufficient funding from NHSE to move the GP review clinics from the GP surgery (for patients known to have AF) into the Trust to ensure that these are completed in a timely way. This is under discussion with the clinical and operational team

- **Demand management** - this work programme aims to pull together the delivery of a range of schemes to support demand management, e.g. improving advice and guidance between clinicians in different care settings, and changing the way outpatient consultations are delivered:

    - training for Teledermatology is almost complete with just one further GP practice to come on board
    - the gynaecology service review is underway and action plans for clinicians and operational teams will shortly be finalised. Learning for larger, more cross-cutting projects will be incorporated into the wider transformation programme.

    For 2019/20, to support demand management and the aspirations of the NHS Long Term Plan, a new programme of elective care transformation is being developed across the West Suffolk Alliance.

The Trust is a prestigious **global digital exemplar (GDE)**, awarded after successfully bidding for a share of £100 million in funding to further improve the way technology is used to benefit patients. The project started in April 2017.

The project is being delivered in four pillars: the development of the e-Care electronic patient record (EPR) solution; the development of services across the wider health community; the Trust's role nationally as part of the NHS GDE programme; and to deliver new digital infrastructure as a key enabler.

The Trust's vision for a digital future has not changed and it continues to be a primary enabler for the organisation's transformation goals, priorities and ambitions. The integration of community health services into the Trust in October 2017 is now driving a realignment of information management and technology initiatives, with the outcomes and benefits designed to drive transformation and a fully integrated patient journey. This realignment is tightly coupled to the Trust's organisational strategy, discussed with and countersigned by colleagues across the care economy and the wider public sector.

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

- **A transformation-led digital trust** – The programme will provide WSFT with a robust, fully digital platform which is paperless at the point of care, resulting in operational efficiencies and improvements in quality of care. Real-time access to accurate information about patients and their care plans, and enterprise-wide scheduling, will ensure seamless and safe handover of care across care settings. Evidence-based decision support such as early warnings for sepsis will optimise care and prevent illness, and efficiency improvements such as device integration will allow more time for direct patient care. Effective use of medications through improved decision support, compliance and reconciliation across settings will also help deliver safer patient care. Many of these, including digital care pathways, early warnings, device integration and improved use of medication management, are already in place either in part or in full
- **Supporting the goals of the integrated care system (ICS)** - The programme aims to support the goals of the emerging Suffolk and North East Essex ICS. A key enabler is the continued deployment of e-Care combined with wider system integration, such as the population health package, initiated in 2018, that will allow the Trust to provide an efficient and effective risk stratification approach to patient management. For example, Suffolk has an older than average population, resulting in increasing demand for services versus affordability. By applying a risk stratification approach and targeting segments of the population (e.g. over 85s), we can intervene in a way that abates demand. A centralised business intelligence and analytics function across the ICS will allow us to perform the sophisticated data analysis which is essential to delivering effective risk stratification

- **Promoting our exemplar digital community** – Working with our electronic patient record partners we will establish ourselves as a model digital community. We will contribute to the increased digital maturity of our local partners, including neighbouring acute hospitals, community services, mental health, ambulance and social care, by providing mentorship in all aspects of deployment, including leadership, informatics and intellectual property (IP) development. We will contribute to delivering digital maturity in both Cerner and non-Cerner sites alike through the sharing of experiences, approaches and solutions, defined as 'blueprinting' with the GDE programme. We will achieve this goal through strengthening existing partnerships such as digitally advanced suppliers, and we will build new partnerships locally and internationally with other exemplar sites or IP development partnerships.

Procurement

The Trust had a three-year procurement strategy (April 2016 to March 2019) that supported the Trust in achieving the following:

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

Procurement actively engages in the utilisation of framework agreements through the NHS supply chain, Crown Commercial Services and the NHS procurement hub to ensure best value is achieved. We undertake benchmarking with acute trusts and NHS organisations across England to ensure pricing and commitment agreements offer the best opportunities for the Trust in line with its size and spend.

Agency rules

The two main clinical staff groups where agency staff are used are medical staff and nurses. During 2018/19 we used the agencies on the CPP Framework preferred supplier list for nursing staff, developed in conjunction with the East of England NHS Collaborative Procurement Hub. The CPP Framework is audited by the procurement hub for framework compliance. This initiative has helped us to bring down the cost of agency nurses to the NHS Improvement capped rates, however the pressures on the service over the winter months has meant that we have not been able to supply at cap for this period.

We have also established a preferred supplier list for agencies supplying medical staff. However, this staff group continues to be a more scarce resource than nursing staff and therefore presents a greater challenge to achieve the same success rates in supplying within cap.

For nursing staff the Trust is now exploring the option of moving away from the CPP Framework and entering into a Master or split vendor contract to try and generate a greater compliance with the capped rates.

The East of England NHS Collaborative Procurement Hub has established a working group to look at the feasibility of establishing a collaborative bank approach with our neighbouring trusts and it is expected that this work will progress in 2019/20.

Capital planning

The Trust has a five-year risk assessed capital strategy that focuses on addressing backlog issues and essential clinical developments in the acute and community sectors. This is further enhanced by an annual prioritisation process for the assessment of investment of capital resources. This is assessed via a multi-professional group using a forced risk ranking process, which assesses the

benefits of investment against four criteria: compliance with the estate strategy; operational/clinical need; financial impact; and statutory compliance. The assessment ensures that:

- risk priorities remain relevant and have not changed
- any changes are incorporated from for example statute, alerts or NHS estates
- any maintenance issues arising in year are considered and incorporated.

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

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

The Trust has recently been awarded £14.9m subject to full business case approval, for transformation of the emergency department. The Trust is aiming to complete this project in 2021/22.

A large part of the estate is more than 44 years old, with an original design life of 30 years - this is reflected in the backlog maintenance costs. In the longer term, the Trust faces the challenge of providing a level of care appropriate to the 21st century; with aging buildings, it is increasingly difficult to meet this challenge. Future changes are likely to be significant and involve working with St. Edmundsbury Borough Council to achieve the best outcome. The Council's planning framework sets out its policies and strategy for Bury St. Edmunds over the next 20 years and includes an option to build a new hospital on a 22 hectare site (Westley site) on the western edge of Bury St. Edmunds. Some preliminary work has been undertaken to establish the level of investment required to provide a new hospital (circa £500m); this excludes purchase of the land, on the assumption this will net off from the sale of the current site.

The annual review had been undertaken to identify the likely implications on the estate over the strategic period arising from the clinical service strategy. The review prioritises schemes and considers the most appropriate location for these developments based on functional suitability of the space and clinical adjacencies. Schemes are considered on a priority/risk basis and the outcomes are broken down into the following **prioritised schemes**:

- Clinical services
- Clinical support services
- Community services
- Non-clinical and corporate services.

Significant schemes planned for delivery in the period are:

- **Staff residences** - the existing staff residential blocks at the front of the site are nearing the end of their structural design life. Feasibility studies have shown that the refurbishment of the existing accommodation is uneconomical due to the level of work required to adapt the units to modern standards, provide structural improvement and remove the asbestos. The delivery of 160 new keyworker accommodation units was completed on schedule and replaced the existing accommodation in March 2019. The existing accommodation will be converted to provide administrative space for staff

- **Acute assessment unit (AAU)** - this scheme seeks to improve the current facilities, which are currently configured as a general ward and improve patient flow associated with the AAU unit and surrounding areas. Co-located to the ED, the new AAU will achieve a reduction in emergency admissions for both medical and surgical patients, improve patient flow and will relieve pressure on the ED, ensuring that the highest acuity patients are seen more quickly. It will also improve ambulance handover times and provide an additional area for ambulance escalation during times of high demand. Phase 1 was completed in November 2018, with phase 2 set to complete in July 2019

- **Emergency department (ED)** - the ED has a number of issues related to flow, in addition to estate that is no longer functionally suitable. Visits from both the intensive support team and the CQC have resulted in recommendations that require a wholesale redevelopment of the department. The recommendations include the need for:
    - separate entrances for ambulance transfers and self-presenting patients
    - separate paediatric waiting and cubicle areas
    - increased clinical capacity (minors, majors, resus and primary care streaming).

  The redevelopment scheme would provide:

    - the solution to a number of patient flow issues and overcome many of the obstacles to reducing the attendance to admission conversion rate
    - effective segregation of ambulance arrivals from other patients into major and minor areas
    - separated paediatric waiting and treatment facilities
    - a paediatric service consistent with our community focused paediatric strategy, centred around the development of a children's assessment unit that would facilitate a primary care driven paediatric service
    - a more appropriate facility for the assessment and treatment of patients with mental health issues
    - the ability for an ED nurse to stream patients directly to a GP, ambulatory emergency care or ED triage depending on their assessment of need
    - an overall increase in capacity to meet the STP activity assumptions
    - effective co-location of ED with the clinical decision unit and the planned acute assessment unit
    - improved patient privacy and dignity.

  Work on the business case to support the development has started and is due to be presented to the Board for approval in November 2019

- **Labour suite** - all of the delivery rooms on the labour suite need to be upgraded as they are not functionally suitable and do not meet the requirements set out in the Health Building Note 09-02 Maternity Care Facilities. The scheme will address privacy and dignity issues by providing en-suite facilities to each delivery room (currently women have to leave the delivery room to access a toilet). The refurbishment will include piped medical air to each room, as currently bottled gas is used. Infection control issues will also be addressed through the provision of a central clinical waste area and sluice. This project is currently underway and due to complete in August 2019

- **Theatre 1** - the plan for 2019-20 includes conversion of this area to a general theatre and alternative bed storage area.

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 the rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

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

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

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

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

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Board reviewed the SDMP in the last 12 months so our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the sustainable development assessment tool (SDAT). The last time we updated the SDAT in 2018, the score increased by 8% to 57%.The increase in score was a result of improved data collection and of completing actions in the annual plan.

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. In 2018 the sustainable development action plan focused on communication to raise the profile of sustainability within the Trust. In 2019 the focus is on green space and biodiversity and carbon and green house gases, as well as embedding the communications plan and ensuring that exampes of good practice are collected and shared across the Trust.

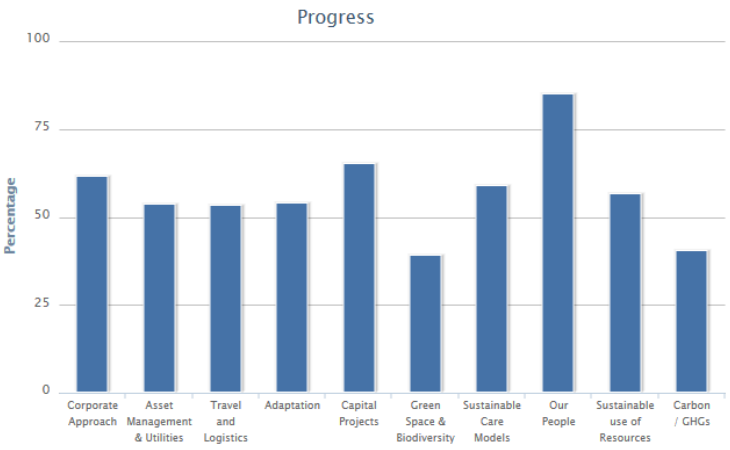
Sustainable development assessment tool outcomes

WEST SUFFOLK NHS FOUNDATION TRUST

Latest assessment score

57%

Module	Score
Corporate Approach	61.64%
Asset Management & Utilities	53.62%
Travel and Logistics	53.12%
Adaptation	53.85%
Capital Projects	65.08%
Green Space & Biodiversity	39.13%
Sustainable Care Models	58.97%
Our People	84.95%
Sustainable use of Resources	56.52%
Carbon / GHGs	40.54%



SUSTAINABLE DEVELOPMENT GOALS

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

Our organisation is clearly contributing to the following SDGs:

Adaptation
Climate change brings new challenges to our business in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Board-approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. The Trust is very aware of its responsibilities to ensure all planning includes measures to address climate-induced hazards. The Trust's emergency plans for severe weather include such awareness, and the overarching command and control capability has a programme of training and exercising to reinforce this.

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

- West Suffolk Clinical Commissioning Group
- Bury local links (active travel)
- Suffolk growth programme board
- East of England Procurement Hub
- Alliance partners – Suffolk County Council, The Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, working closely with the West Suffolk CCG and with wider stakeholders such as the ambulance service, independent care providers the voluntary community sector, employers, the education sector and business.

Energy

Resource		2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	20,414,927	22,915,910	25,103,388	24,605,975
	tCO_2e	4,272	4,789	5,322	5,217
Oil	Use (kWh)	2,751,124	2,823,162	1,075,600	0
	tCO_2e	879	895	351	0
Electricity	Use (kWh)	4,032,393	3,699,138	2,808,885	4,594,967
	tCO_2e	2,318	1,912	1,252	2,048
Total energy CO_2e		7,469	7,596	6,925	7,265
Total energy spend		£1,097,061	£1,073,831	£1,047,805	£996,002

Source of data 2015 – 2018 - ERIC returns to the Information Centre.
2017/18 data has been updated to reflect the final reported position. 2018/19 data correct at 12/4/19

Solar panels Quince House

	2018/19
Energy **output** PV panels Quince House	6,381

Combined heat and power unit

	2015/16	2016/17	2017/18	2018/2019
Fossil energy **input** to the CHP system (kWh)	17,269,775	16,998,484	15,942,272	14,514,629
Electrical energy **output** of CHP system (kWh)	5,804,997	5,656,174	5,262,992	5,144,790
Thermal energy **output** of CHP system (kWh)	6,178,000	6,448,000	2,700,000*	*4,160030

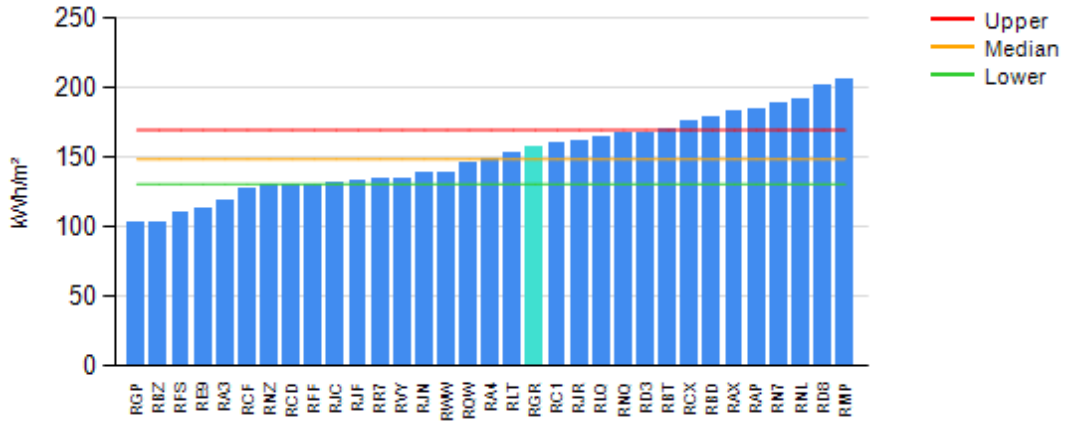
*Note the CHP heat meter was faulty for three months leading to a lower than expected reading. (2018-19 Data correct at 11/4/19)

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

- Continuated operation of the site's combined heat and power (CHP) unit 24/7
- Continuing to install improved energy efficient engineering plant under the Trust backlog programme
- Continued use of PC power saver system which turns off PC safely overnight if left on.

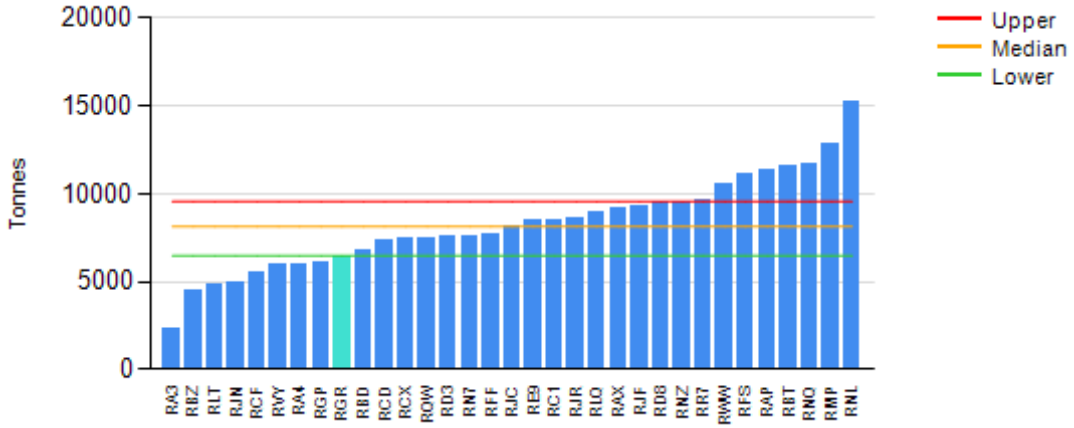
The CRC cost for 2018/19 is only approximately £360 greater than in 2017/18 despite an increase in the carbon cost (£/tC02) from £17.50 to £18.30 per tCO2, this is due to the efficient running of the CHP.

Electrical energy consumed per occupied floor area (small acute)



Source: NHS Digital

CO2 emissions (small acute)



Source: NHS Digital

Paper

Paper		2015/16	2016/17	2017/18	2018/19
Volume used	Tonnes	55	48	45	44
Carbon emissions	tCO_2e	52	46	43	41

Travel

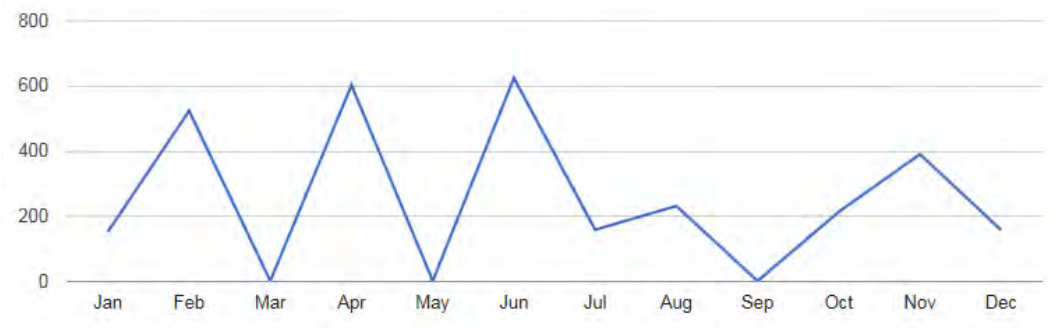
We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.
A travel expenses policy has been approved by the Trust executive group which reiterates the Trust travel hierarchy and the Trust's expectations regarding business travel. In addition the travel plan has been reviewed and active travel options are promoted through the staff newsletter.
In 2018 WSFT was presented with a Gold Award by Bury Local Links in recognition of the progress made on the travel plan and initiatives to promote active travel.

Re-use

The Trust continues to use and promote the Warp It reuse portal which was launched in November 2016; it allows colleagues to advertise surplus furniture and stationery for reuse within the Trust. The Warp It group has grown to 247 members and to date, in addition to avoided re-procurement costs of £25,100, has avoided 2,624kg of waste and saved 10,217kg CO2e emissions.

Warp It savings 2018 (£s)

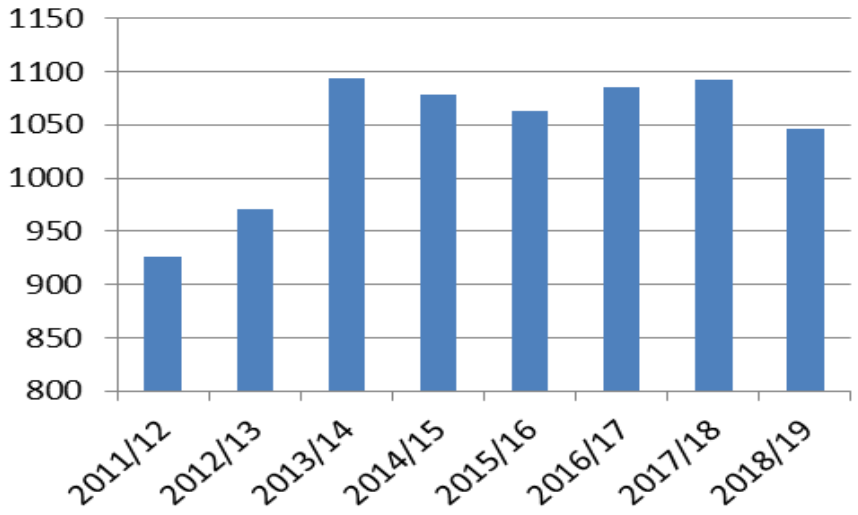


Waste (total clinical and non-clinical)

Waste		2015/16	2016/17	2017/18	2018/19
Recycling	(tonnes)	198.67	231.96	254.14	228.28
	tCO_2e	3.97	4.87	5.53	4.88
Other recovery	(tonnes)	0.00	398.76	393.94	364.94
	tCO_2e	0.00	8.37	8.57	7.81
High temp disposal	(tonnes)	457.35	455.06	444.10	452.76
	tCO_2e	100.16	100.11	97.70	99.7
Landfill	(tonnes)	406.46	0.00	0.00	0.00
	tCO_2e	99.35	0.00	0.00	0.00
Total waste (tonnes)		1062.48	1085.78	1092.18	1045.98
% Recycled or re-used		19%	21%	23%	21.8%
Total waste tCO_2e		203.48	113.36	111.80	112.39

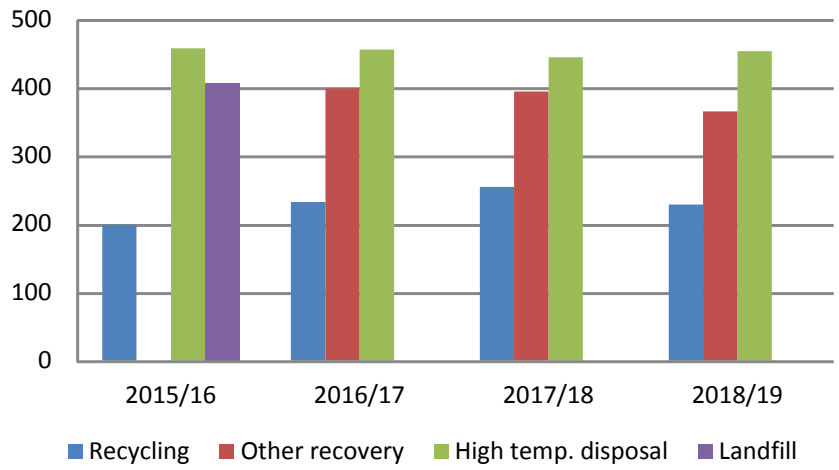
Data source – quarterly waste returns, data correct at 5/4/19

Total waste (tonnes)



Data source – quarterly waste returns, data correct at 5/4/19

Waste breakdown (tonnes)



Following the success of the plastic bottle recycling trial run in the Time Out restaurant and Courtyard Café and the start of a new domestic waste contract, plastic recycling has been reintroduced at the

Trust. In addition to areas included in the trial, a number of other areas have now been included such as Quince House, purchasing and the Education Centre. In the day surgery unit recycling champion Adrian Nunn has worked with colleagues to implement plastic recycling, collecting approximately 40kg per fortnight. In the six months from October 2018 to March 2019 approximately 2.6 tonnes of plastic from the Trust has been recycled.

The waste and energy officer and sustainability officer are working together on a recycling action plan to increase the volume of recycling in the Trust. Our Trust target is to recycle 30% of total waste. In 2018 -2019, 21.8% was recycled, a slight decrease on the previous year's figures. This is in part due to a signifcant reduction in the amount of confidential (24% less) and non-confidential paper (19.6% less) recycled in 2018-2019 than in the previous year. The relocation of finance, human resources, estates and facilities and Trust office staff to Quince House, when a large volume of historic paper records were stored digitally, accounts for the higher level of paper recycling in 2017-2018.

Reusable coffee cups were launched in the staff restaurant in June 2018, with users offered their first hot drink free of charge and a saving of 10p on the cost of every further hot drink. The original order of 500 cups was soon sold and a further 200 have since been ordered.

Finite resource use – water

Water		2015/16	2016/17	2017/18	2018/19
Mains water	m^3	69,442	71,300	96,682	121,030
	tCO_2e	63	65	88	110
Water and sewage spend	£	£145,115	£148,800	£205,547	£263,086

Source of data 2015 – 2018 - ERIC returns to the Information Centre.
2017/18 data has been updated to reflect the final reported position. 2018/19 data correct at 12/4/19

Water usage increased in 2017/18, and to a greater extent in 2018/19, as a consequence of sterile services moving onto the WSH site. Since December 2018, the new staff residences also impacted on water usage.

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:

- **Cardiac centre** - the cardiac centre has been fitted with low energy LED light fittings; with individual sensors fitted to many rooms ensuring the lights are off if no one is there. The lighting in the bed bays mimics the circadian rhythm so the power consumed will be reduced at different times of the day. The cardiac centre has been fitted with a low energy VRV HVAC system, greatly reducing the energy to heat or cool the space
- **New accommodation complex** - the new accommodation has been fitted with energy saving LED lighting throughout and all white goods are AAA rated. In addition, all the domestic boilers are fully condensing low energy and the tumble dryers are also low energy condensing machines. Even the cooking facilities have environmentally friendly induction hobs. Induction cooking is a more energy efficient option than other forms of hob cooker as the efficiency allows almost all of the heat generated to be transferred into the food; the induction hobs use considerably less energy than other hobs types. In the individual en-suite bath rooms the WC are dual flush systems to help conserve water
- **Communication** – a key action for the sustainable development steering group in 2018 was to establish a communications plan formalising the process of sharing details of sustainable development with staff and stakeholders. The plan is now embedded as part of the work of the group with monthly articles in the staff newsletter, posters in the Trust, a stand at events such as the preceptorship training days and in Timeout restaurant to highlight national sustainability day

- **Small and medium enterprises** - the purchasing department continues to monitor and collate non-pay spend with local small and medium enterprises, and details have been shared with colleagues at Nottingham Trent University which will be compiling examples into a report for the sustainable development unit (SDU). Its aim is to document best practices so that other organisations can achieve improved SDAT scores
- **Ultrasound service – Haverhill** - in November 2018 the Trust opened a new ultrasound service in Haverhill, 18 miles from the hospital site. The service operates one day a week and means that patients are able to have scans locally without having to travel to West Suffolk Hospital, Addenbrooke's or Newmarket Hospital. This saves a considerable numbers of journeys to the respective hospitals, helping to reduce on site congestion and also reducing CO2e emissions.

Excellence in sustainability reporting

The Trust was pleased to have been recognised for excellent sustainability reporting as part of its annual report 2017/18, receiving a certificate of excellence, awarded by the SDU, NHS Improvement and the Healthcare Financial Management Association. The SDU, which works across the health and care sector on behalf of NHS England and Public Health England, conducted an analysis of all provider and clinical commissioning group (CCG) annual reports to evaluate sustainability sections. Fifty-five trusts and 42 CCGs (around 22%) have been selected for recognition out of 432 organisations across England.

2. Accountability report

2.1 Governors' report

2.1.1 Responsibilities

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

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

2.1.2 Composition

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

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

Peter Alder
Mary Allan
Florence Bevan
June Carpenter (lead governor until 30 November 2018)
Justine Corney
Jayne Gilbert
Robin Howe[2]
Gordon McKay
Barry Moult
Jayne Neal
Adrian Osborne
Joe Pajak
Margaret Rutter[1]
Jane Skinner
Liz Steele (lead governor from 1 December 2018)

[1] Resigned from Council of Governors December 2018
[2] Appointed to Council of Governors January 2019

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

Peta Cook
Javed Imam
Amanda Keighley
Garry Sharp
Martin Wood

Partner governors – nominated by partner organisations of WSFT

Judy Cory	Friends of West Suffolk Hospital
Dr Mark Gurnell	University of Cambridge
Dr Andrew Hassan	West Suffolk Clinical Commissioning Group
Laraine Moody	West Suffolk College also representing University Campus Suffolk
Councillor Rebecca Hopfensperger	Suffolk County Council
Councillor Sara Mildmay-White	St Edmundsbury Borough Council, also representing Forest Heath District Council, Mid-Suffolk District Council and Babergh District Council

Governor attendance at council of governors meetings 2018/19

There were five formal meetings of the Council of Governors: 17 May 2018, 9 August 2018, 11 September 2018 (Annual Members Meeting), 14 November 2018, 12 February 2019, with the following Governor attendance:

Name	Title	Attendance (out of five meetings)
Peter Alder	Public governor	4
Mary Allan	Public governor	3
Florence Bevan	Staff governor	5
June Carpenter	Public governor	4
Peta Cook	Staff governor	5
Justine Corney	Public governor	3
Judy Cory	Partner governor	4
Jayne Gilbert	Public governor	3
Mark Gurnell	Partner governor	2
Andrew Hassan	Partner governor	4
Rebecca Hopfensperger	Partner governor	3
Robin Howe[2]	Public governor	0 (of 1)
Javed Imam	Staff governor	3
Amanda Keighley	Staff governor	5
Gordon McKay	Public governor	5
Sara Mildmay-White	Partner governor	5
Laraine Moody	Partner governor	2
Barry Moult	Public governor	4
Jayne Neal	Public governor	5
Adrian Osborne	Public governor	5
Joe Pajak	Public governor	5
Margaret Rutter[1]	Public governor	1 (of 4)
Garry Sharp	Staff governor	3
Jane Skinner	Public governor	5
Liz Steele	Public governor	4
Martin Wood	Staff governor	5

[1] Resigned from Council of Governors December 2018
[2] Appointed to Council of Governors January 2019

In attendance at these meetings were: Sheila Childerhouse, chair (4) Dr Richard Davies, non-executive director (5); Helen Beck, chief operating officer (2); Craig Black, executive director of resources (1); Jan Bloomfield, executive director of workforce and communications (1); Dr Stephen Dunn, chief executive (3); Angus Eaton, non-executive director (4); Dr Nick Jenkins, executive medical director (3); Gary Norgate, non-executive director (3); Louisa Pepper, non-executive director, appointed in September 2018 (3); Rowan Procter, executive chief nurse (1); Alan Rose, non-executive director (5).

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. A number of governors attend and observe the monthly Board of directors meetings. This gives them an insight into and understanding of the performance of the Trust, particularly from a quality and finance perspective and provides an insight into the role and performance of the non-executive directors (NEDs).

The NEDs present a summary of the finance report and quality and performance report at the council of governors meetings.

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

Joint council of governors and Board workshops took place in September 2018 and March 2019. The September workshop focused on the west Suffolk system estate strategy and the March workshop focused on the operational plan for 2019-20.

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

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

Governors continue to take part in the weekly quality walkabouts. These are led by the chief executive or chair and also include an executive director or NED on each occasion. This gives governors a greater understanding of services across the organisation, as well as providing an opportunity for them to interact with patients, staff and directors. Governors also take part in monthly environmental walkabouts and area observations. The purpose of the environmental walkabouts is to support the department managers in ensuring that the Trust's corporate identity and values are represented accurately. The area observations are a new initiative where a governor discreetly sits in an outpatient area for an hour and observes the environment, general atmosphere, staff interactions and anything else they feel is enhancing or adversely affecting patient experience. This information is fed back to the manager and an action plan monitored through the patient and carer experience group.

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

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

- Joint council of governors and Board workshops – west Suffolk system estate strategy and operational plan (27 September 2018 and 13 March 2019)
- Governor training day with external trainer – recap on the role of the council of governors and NHS quality and NHS finance; using the well-led framework as a tool to holding to account; application of the Trust's FIRST values within the council of the governors; and listening and questioning skills (22 January 2019)
- Governors were invited to attend quality presentations to the Trust's quality and risk committee on 28 September 2018, 14 December 2018 and 29 March 2019.
- A briefing for new governors was provided to update them on historical issues with pathology services in September 2018.

2.1.5 Membership

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

Public membership

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

Patients and members of the public who reside in the following areas are eligible to join our public constituency (these will be subject to change from 1 April 2019 to reflect the updated electoral boundaries):

Babergh:	Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
Forest Heath:	All Saints, Brandon East, Brandon West, Eriswell & the Rows, Exning, Great Heath, Iceni, Lakenheath, Manor, Market, Red Lodge, St Marys, Severals, South.
Ipswich	Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmswell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddenham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hessett, Wetheringsett, Woolpit, Worlingworth.
South Norfolk:	Bressingham and Burston, Diss and Roydon
St Edmundsbury:	Abbeygate, Bardwell, Barningham, Barrow, Cavendish, Chedburgh, Clare, Eastgate, Fornham, Great Barton, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Ixworth, Kedington, Minden, Moreton Hall, Northgate, Pakenham, Risby, Risbygate,

	Rougham, Southgate, St Olaves, Stanton, Westgate, Wickhambrook, Withersfield
Suffolk Coastal	Aldeburgh, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Grundisburgh, Hacheston, Kesgrave East, Kesgrave West, Kirton, Leiston, Martlesham, Melton, Nacton & Purdis Farm, Orford & Eyke, Peasenhall & Yoxford, Rendlesham, Saxmundham, The Trimleys, Tower, Wenhaston & Westleton, Wickham Market, Woodbridge.
Waveney	Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Gunton & Corton, Halesworth, Harbour, Kessingland, Kirkley, Lothingland, Normanston, Oulton, Oulton Broad, Pakefield, Southwold & Reydon, St Margaret's, The Saints, Wainford, Whitton, Worlingham, Wrentham.

Staff membership

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

In addition, staff who exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months are also eligible to become staff members unless they choose to opt out. For clarity this does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

Membership numbers

At 31 March 2019 there were 5,974 public members and 4,656 staff members.

Membership strategy

The Trust's membership strategy is reviewed on an annual basis by the engagement committee for consideration by the council of governors and approval by the Board of directors. We aim to maintain and, where possible, increase our public membership and to ensure that staff membership is maintained at an appropriately high level. Experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on WSFT.

Governors continue to use a short questionnaire to engage with members of the public during member recruitment initiatives. As well as recruiting new members this provides valuable feedback from patients and the public on their experiences and views of WSFT.

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

Criteria	Current March 2019	Target (Mar 2019)
1. Achievement of the recruitment target: a. Total number of public members b. Staff opting out of membership	 **5,974** **<1%**	 6,000 <1%
2. Achieve a representative membership for our membership area, priorities for action: a. Age – recruitment of under 50s	 **1,145**	 1,250

b. Engagement and recruitment events in all market towns of membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	**80%**	100%
3. An engaged membership measured by: a. number of member events held April 2017 - March 2019	**6**	6
b. member attendance – total all events	**984***	600*
c. annual members' meeting attendance (each year)	**261 (2017)** **330 (2018)**	200

* Includes people attending annual members' meeting

During the past year the Trust held three 'special interest' events on services provided by WSFT. These have proved extremely popular with a total of 547 people attending the three events. These events have also been used to provide feedback on the services provided by WSFT.

Contact procedures for members

Contact details for the 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 news at the Trust, and also gives details of how to contact the Trust.

2.1.6 Nominations committee

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

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

In April 2018 the nominations committee agreed a process for the recruitment of a NED position which would become vacant in July 2018. A successful appointment was subsequently made and approved at a closed session of the council of governors in August 2018.

In July 2018 the nominations committee reviewed the feedback from the appraisals of the NEDs and key messages that would be fed back to each individual. They also reviewed and agreed the content of the senior manager remuneration policy; and supported a recommendation for the remuneration of the chair and NEDs and the appointment of a new vice chair, both of which were approved at a closed session of the council of governors in August 2018.

In October 2018 the committee reviewed the feedback from mid-term appraisal for the chair following their appointment on 1 January 2018.

In January the committee agreed to recommend to the council of governors that a NED, whose second term of office would end in August 2019, should be offered a further one year term. The remuneration of the chair and NEDs was also reviewed and a recommendation approved. Both these recommendations were approved at a closed session of the council of governors in February 2019. The committee also reviewed the NED appraisal process; recommendation was made to and approved by the council of governors in February 2018.

Attendance at nominations committee meetings 2018/19

Name	Title	Attendance (out of four)
Sheila Childerhouse (chair)	Chair	3 (of 3)*
June Carpenter	Public governor (lead governor until 30/11/18)	2 (of 3)
Justine Corney	Public governor	3
Sara Mildmay-White	Partner governor	2
Barry Moult	Public governor	3
Liz Steele	Public governor (lead governor from 1/12/18)	4
Martin Wood	Staff governor	3

Meeting dates: 19 April 2018; 13 July 2018; 30 October 2018; 29 January 2019

* Note – Sheila Childerhouse did not attend the meeting on 30 October 2018 due to a conflict of interest.

2.2 Directors' report

2.2.1 Responsibilities

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

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

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

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

2.2.2 Composition

(a) Non-executive directors

Mrs Sheila Childerhouse – NED and chair
(Appointed: from 1 January 2018 until 31 December 2020)

Areas of special interest/responsibility: chair of quality and risk committee; member of scrutiny committee, remuneration committee and chair of the governors' nominations, appointments and remuneration committee. Sheila is chair of the Board of directors and council of governors of WSFT and also chair of the STP chair group.

Until recently Sheila was chair of Anglian Community Enterprise (ACE) and a non-executive director of East of England Ambulance Service NHS Trust. She is a trustee of the East Anglia's Children's Hospice (EACH) and works as an executive coach.

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

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

Areas of special interest/responsibility: lead NED for the clinical safety and effectiveness committee; member of the remuneration committee, audit committee, quality and risk committee and revalidation support group; NED link to medical director; and lead NED for learning from deaths, end of life and children's services including safeguarding.

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

Independent director – yes (see Note 1)

Mr Angus Eaton - NED
(Appointed: 1 January 2018 until 31 December 2020)

Areas of special interest/responsibility: chair of audit committee and remuneration committee; member of the charitable funds committee; NED link to director of resources; lead NED for health and wellbeing programme.

Angus is a solicitor with wide executive and board experience. Currently, he is managing director of Consumer Legal Services and chief risk officer for Slater and Gordon. Previous experience includes: UK strategy and transformation director at Aviva and a board director of Aviva's Turkish Life Joint Venture; MD Aviva's UK Commercial General Insurance business; chief risk officer, Aviva's UK and Ireland general insurance business; Aviva Group Regulatory and operational risk director and group legal director

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

Mr Gary Norgate – NED and senior independent director
(Appointed: 1 September 2013 until 31 August 2016; reappointed 1 September 2016 until 31 August 2019; reappointed 1 September until 31 August 2020)

Areas of special interest/responsibility: Chair of scrutiny committee and charitable funds committee; second lead for clinical safety and effectiveness committee; member of remuneration committee, audit committee, digital programme board, clinical excellence & discretionary awards committee; and lead NED for digital, whistleblowing and procurement.

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

Gary is director of Global Solution Specialists at BT Plc. He has previous NED experience with Cambridge Community Services NHS Trust and Suffolk Mental Health Partnership NHS Trust.

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

Mrs Louisa Pepper– NED
(Appointed: 1 September 2018 until 31 August 2021)

Areas of special interest/responsibility: Member of the audit committee, quality & risk committee, remuneration committee, lead NED for corporate risk committee and second lead for patient experience committee; lead NED for safeguarding adults, security and emergency preparedness, resilience and response (EPRR).

Louisa joined Suffolk Constabulary in 1991, gaining promotion through all ranks from constable to assistant chief constable, until her retirement in September 2017. During this time 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.

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

Mr Alan Rose – NED and deputy chair
(Appointed 1 April 2017 until 31 March 2020)

Areas of special interest/responsibility: member of audit committee, scrutiny committee, quality and risk committee, remuneration committee, lead NED for patient experience committee, and second lead for corporate risk committee; lead NED for referral to treatment (RTT) and patient experience and public engagement.

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

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

Mr Steve Turpie – NED and deputy chair (resigned 31 May 2018)

(Appointed: from 1 December 2011 (authorisation as FT) until 28 February 2014; reappointed 1 March 2014 until 28 February 2017; reappointed 1 March 2017 until 28 February 2019)

Areas of special interest/responsibility: chair of audit committee (until May 2018); member of remuneration committee and deputy chair of the Trust. NED lead for procurement and paediatrics, and NED link to director of resources.

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

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

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

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

(b) Executive directors

Dr Stephen Dunn CBE – chief executive

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

Stephen joined the Trust as chief executive in November 2014 from the NHS Trust Development Authority where he was regional director of delivery and development for the south.

Stephen's previous experience was as a director of policy and strategy at NHS Midlands and East; director of strategy and provider development at NHS East of England; and senior civil servant at the Department of Health.

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

Stephen was awarded the prestigious title of Commander of the Order of the British Empire (CBE) in the New Year's Honours 2019.

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

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

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

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

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

Dr Nick Jenkins - executive medical director

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

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

Nick was on the NHS Leadership Academy Executive Fast Track Programme. He is a CQC executive reviewer.

Mrs Rowan Procter – executive chief nurse

Areas of responsibility: joint operational responsibility with the chief operating officer and medical director for the operational management and delivery of all clinical services. Also professional leadership for nurses, midwives and allied health professionals, nursing strategy and nurse management, professional education, clinical governance and quality improvement, safeguarding children and vulnerable adults, risk management, integrated governance, complaints and litigation and chaplaincy and director of infection prevention and control . Rowan is also CQC lead for the Trust and a CQC executive reviewer.

Rowan was appointed as interim executive chief nurse in November 2015 and was successful in her substantive appointment in July 2016.

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

Mrs Helen Beck – Chief operating officer

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

Helen joined the Trust in September 2014 as deputy chief operating officer, having previously held positions at Cambridge University Teaching Hospital as senior operational manager and theatre manager.

Helen has 34 years' experience in the NHS and is a registered general nurse with a diploma in theatre nursing.

Mrs Jan Bloomfield – executive director of workforce and communications*

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

Jan joined the Trust in February 1991 and was previously deputy personnel manager at University College Hospital, London. She is a co-opted board governor at West Suffolk College, governor at Sybil Andrews Academy, management-side chair of the Regional Social Partnership Board, chair of the East of England HR Directors' Network and patron of Suffolk West NHS Retirement Fellowship.

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

* Non-voting director

Mrs K Vaughton, who is employed and remunerated by West Suffolk Clinical Commissioning Group, attends WSFT Board meetings on a regular basis. This is in her capacity as the director of integration and partnerships for which a one year secondment to WSFT started in January 2019.

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 at the following address: Trust secretary, Foundation Trust Office, West Suffolk NHS Foundation Trust, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ.

2.2.4 Appointment of chair and non-executive directors

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

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

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

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

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

2.2.5 Evaluation of the Board of directors' performance

Attendance at Board of directors meetings 2018/19

Name	Title	Attendance (out of 10)
Sheila Childerhouse	Chair	10
Helen Beck	Interim chief operating officer	9
Craig Black	Executive director of resources	10
Jan Bloomfield	Executive director of workforce and communications	9
Richard Davies	Non-executive director	10
Stephen Dunn	Chief executive	10
Angus Eaton	Non-executive director	7
Nick Jenkins	Executive medical director	9
Gary Norgate	Non-executive director	10
Louisa Pepper [(a)]	Non-executive director	4 (of 6)
Rowan Procter	Executive chief nurse	10
Alan Rose	Non-executive director	10
Steven Turpie[(b)]	Non-executive director	1 (of 2)

[(a)] Louisa Pepper was appointed as a non-executive director from 1 September 2018
[(b)] Steven Turpie left the Trust on 31 May 2018

Meeting dates
27 April 2018, 25 May 2018, 29 June 2018, 27 July 2018, 28 September 2018, 2 November 2018, 30 November 2018, 25 January 2019, 1 March 2019, 29 March 2019

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

The Trust's governance structure ensures reports are received by the Board through a dedicated committee with oversight for quality and risk (the quality and risk committee). The minutes of each meeting of the quality and risk committee are received by the Board. The separation of this accountability and reporting line from the audit committee is fully consistent with good practice, allowing the audit committee to provide a truly independent and objective view of the Trust's internal control environment.

The escalation arrangements within the governance structure ensure timely and effective escalation from directorates and specialist committees to the Board via the trust executive group. The 'red risk report' and 'Serious incident, inquests, complaints and claims report' are standing agenda items on the Board and include escalation of risks from Board sub-committees and other sources.

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

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

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

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

2.2.6 Audit committee

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

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

External audit
BDO LLP (BDO), WSFT's external auditors, reports to the council of governors through the audit committee. BDO's accompanying report on the financial statements is based on its examination conducted in accordance with the audit code for NHS foundation trusts, as issued by NHSI, independent regulator of foundation trusts.

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

As part of the approval of the annual external audit plan, the external audit process is subject to review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The audit committee meets with the external auditor without officers present on an annual basis. The council of governors reappointed the external auditors on 8 February 2017 for the financial years 2017/18 to 2019/20. The cost of statutory services for the 2018/19 financial year was £59,000 (2017/18; £59,000).

Non-audit work may be performed by the external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For all such assignments the audit committee will be advised, which will ensure that objectivity and independence is safeguarded. No such work was undertaken in 2018/19.

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)
Sheila Childerhouse	Trust chair	3
Richard Davies	Non-executive director	3 (of 4)
Angus Eaton	Non-executive director (chair from June 2018)	4
Louisa Pepper[(a)]	Non-executive director	0 (of 2)
Gary Norgate	Non-executive director	4
Alan Rose	Non-executive director	3
Steven Turpie[(b)]	Non-executive director (chair until May 2018)	1 (of 1)

[(a)] Louisa Pepper was appointed as a non-executive director from 1 September 2018
[(b)] Steven Turpie left the Trust on 31 May 2018

Meeting dates: 25 May 2018, 27 July 2018, 2 November 2018 and 25 January 2019

2.2.7 Well-led framework

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

Details of improvements that we have made in patient safety are given elsewhere in this report and in section 2.6 (annual governance statement) and section 3 (quality report) which provides information

on external reviews and audits. The annual governance statement also describes the arrangements the Board of directors has put in place to delivery and monitor quality.

The Board of directors reviews the arrangements in place to deliver the NHS Improvement quality governance framework as part of the annual governance review it undertakes; this includes a review of relevant assurances within the board assurance framework. During 2017/18 the Board used the 'well-led' framework published by NHSI and CQC as the basis of this review. Based on the internal work undertaken and the CQC's well-led rating of WSFT as outstanding, the Board and NHSI have agreed that external evaluation of the Board and governance of the Trust will take place in 2019-20.

2.2.8 Details of consultation

The Trust consulted with members of staff and the public regarding the proposed development of Churchfield Road during 2018/19. A public exhibition was held at Sudbury Health Centre on 13 November 2018 to outline the proposal. Members of the public were made aware of the event via adverts in local newspapers, leaflet inserts in local newspapers and a web page was developed which contained the details of the public exhibition boards; this went live on 13 November 2018. Local councillors, members of the local parish council and campaign group Sudbury WATCH were made aware of the event. The first 30 minutes of the exhibition were limited to councillors, with general members of the public able to attend from 11.30 am onwards. Ninety-nine people were recorded as attending the event, with 68 people completing questionnaires. The consultation window for comments closed on 23 November 2018.

Public engagement continued throughout the year in the form of our patient user group, VOICE, which has increased its membership of patients, family carers and relatives. Some of the projects the group has been involved in during the year include:

- Always Event® inpatient welcome booklets
- Experience of care week
- Learning from deaths, including being used as a national case study for good practice in implementing the learning from deaths review process in the NHS
- Organisational equality, diversity and inclusion objectives
- Elective care transformation programme co-design
- Overnight stays for partners on our postnatal ward
- Endometrial cancer focus group
- Patient portal user group
- New acute assessment unit building works and plans
- Quality improvement training.

The group also intends to come together with other public representative groups from across the West Suffolk Alliance to review engagement strategies and opportunities.

We are also in liaison with our colleagues at Healthwatch Suffolk as part of an exciting new project in which we will be piloting virtual language interpreting, which is facilitated via a video conferencing platform. Healthwatch Suffolk will be working with us to engage with the public and analyse how the project progresses; sharing learning across the county for the benefit of our community.

2.2.9 Other disclosures

Companies act disclosures

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

- Important events since the end of the financial year affecting WSFT
- An indication of likely future developments
- Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees

- Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Actions taken in the financial year to encourage the involvement of employees in WSFT's performance
- Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of WSFT.

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Cost allocation

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 2018/19.

Statement as to disclosure to auditors

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

Better payment practice code

The Trust is a signatory to the Better Payment Practice Code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust has paid £1,942 interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2018/19 (2017/18 £177.61).

	2018/19		2017/18	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	56,710	139,168	56,779	128,590
Total non-NHS trade invoices paid within target	28,527	76,513	21,168	69,998
Non-NHS trade invoices paid within target (%)	**50.3%**	**55.0%**	**37%**	**54%**
Total NHS trade invoices paid in the year	1,794	49,332	2,087	73,198
Total NHS trade invoices paid within target	661	35,846	435	61,004
NHS trade invoices paid within target (%)	**36.8%**	**72.7%**	**21%**	**83%**

Statement regarding the annual report and accounts

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

Dr Stephen Dunn
Chief executive
28 May 2019

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 July 2014, is based on the principles of the UK corporate governance code issued in 2012.

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

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

2.4 NHS Improvement's single oversight framework

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

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

The Trust has been placed in segment 2, the second best category. This segmentation information is the Trust's position at 24 April 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	2	4	4	4
	Liquidity	4	4	4	4	2	3	3	4
Financial efficiency	I&E margin	4	4	4	4	2	4	4	4
Financial controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1	1	1
Overall scoring		**3**	**3**	**3**	**3**	2	3	3	3

2.5 Statement of accounting officer's responsibilities

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require West Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of West Suffolk NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the accounts direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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 Trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Dr Stephen Dunn
Chief executive
28 May 2019

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2018 to 31 March 2019

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

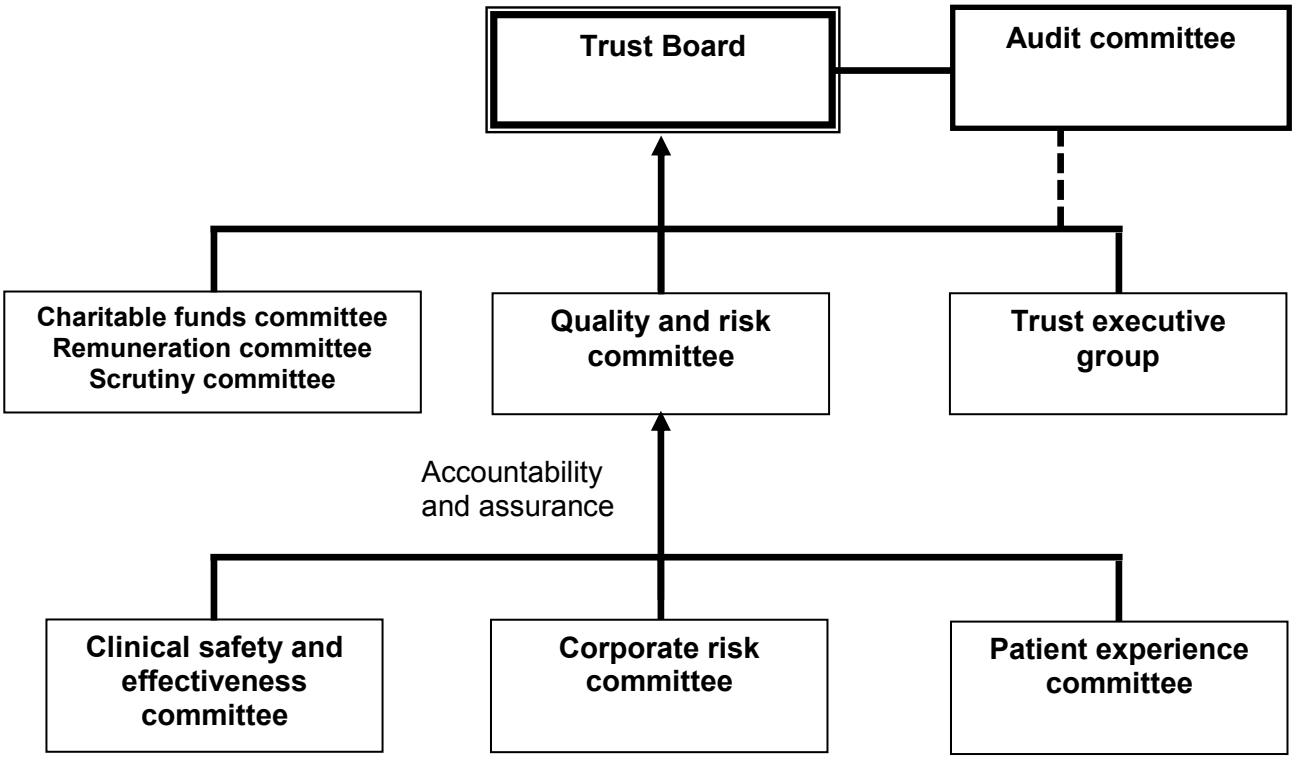
The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to foundation trusts. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust 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. The audit committee independently reviews the effectiveness of risk management systems, ensuring that all significant risks are properly considered and communicated to the Board of directors. It reviews implementation of the board assurance framework to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained.

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

Chart 1: Governance structure



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

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

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

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

Guidance and training 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.

The risk and control framework

The risk management strategy and policy sets out the key responsibilities for managing risk within the organisation, including the ways in which risk is identified, evaluated and controlled.

Risk is assessed at all levels in the organisation from the Board of directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed. Risk assessment information is held in an organisation-wide risk register. The 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 Board retains oversight of significant (red) operational, corporate and strategic risks. The Board reviewed its risk appetite during 2018/19 and this will be further developed during 2019/20.

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

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

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

- **Care Quality Commission (CQC)** – an overall rating of 'outstanding'
- **Performance against national targets**, meeting a number of national targets in 2018/19
- **Awarded status of global digital exemplar**
- **Diagnosis rates in west Suffolk for early stage cancers are the best in the country** (for the last three years)
- **Excellent reputation for teaching** – both undergraduate and graduate.

It has been an impressive year for the Trust, with many accolades to be proud of.

- Finalist in the Health Service Journal Awards 2018 'Using Technology to Improve Efficiency' category, for our work in piloting new digital communications tool, Medic Bleep
- Finalist in the Student Nursing Times Awards 2019 'Student Placement of the Year: Hospital' category, in recognition of our nursing student support programme
- Rated by our staff as the best general acute in the country for giving them control and choice over how they do their work in the latest NHS staff survey (2018)
- Rated as the top hospital in England, Wales and Northern Ireland for meeting best practice criteria for hip fracture treatment by the National Hip Fracture Database

- Chief executive Dr Steven Dunn awarded a CBE for services to health and patient safety in the prestigious Queen's New Year Honours list
- Fifty women across the Trust announced as 'inspirational women of west Suffolk' as part of NHS 70th birthday celebrations
- Scored top in the East of England for doctors' overall training satisfaction in acute trusts, in the General Medical Council's national training survey (2018)
- Named as one of the CHKS Top Hospitals Award Winner for 2018
- Hannah Sharland, estates and facilities project manager, was awarded the individual development award at the recent Health Estates and Facilities Management Association (HefmA) awards
- Our My WiSH Charity was chosen as the regional winner in the Patient and Public Involvement Award category of the NHS70 Parliamentary Awards.
- Latest sentinel stroke national audit programme (SSNAP) data rates WSH as a level A (highest).

This accolades go hand-in-hand with some of our ongoing developments and achievements across the past 12 months. As a snapshot:

- Delivery of a £5.2m cardiac suite that allows us to deliver procedures like angiography and pacemaker fitting on site for the first time
- Opening of a new acute assessment unit (AAU) that has transformed how we assess and treat our emergency patients
- Introducing Medic Bleep, a digital app to replace physical bleeps, that has been evidenced to save valuable staff time (average 48-minutes per shift for junior doctors and 21-minutes per shift for nurses) so they can spend more of it caring for patients
- Linking our electronic patient care record in the emergency department with Cambridge University Hospitals NHS Foundation Trust, so that clinicians at either site can access information on a patient's record held by either trust
- Helping the West Suffolk Clinical Commissioning Group area to achieve the fewest excess bed days in the country (the term used to describe where people are still in hospital when they no longer need to be there).

But, we also have some challenges:

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

  Performance against the four-hour standard during 2018-19 was extremely challenging - flow through the hospital affected our ability to deliver, with planned escalation capacity unable to meet the level of demand seen. This required 'surge' beds to be open for prolonged periods.

  Planning for winter began in summer 2018. Additional bed capacity was delivered when the new cardiology facility and acute assessment unit (AAU) opened. The bed capacity model was refreshed and ward areas were identified for escalation and surge (extra capacity to be used during exceptional peaks in demand). A workforce plan was developed and extensive recruitment undertaken to staff the additional capacity. Overseas recruitment and the move to bay-based nursing were two key components of the workforce plan.

  A number of demand management initiatives were also planned to mitigate the growing numbers of emergency department (ED) attendances and admissions. These included implementation of discharge to assess pathway one and trial of a rapid intervention vehicle (RIV) staffed by paramedics and our early intervention team (EIT). By late summer it became apparent that we would be unable to recruit sufficient staff to safely open all of the additional bed capacity and the plans were therefore adapted with the procurement of 20 additional community beds for early 2019, when it was predicted that demand would be at its highest.

Demand during winter was higher than the planning assumptions - January 2019 saw 11% more attendances at ED (equating to 700 patients extra through the door) and 10% more admissions (300 more patients admitted) than the previous January; compared with the 4.5% predicted growth. In addition to the increases in demand we have been unable to maintain the reduction in stranded and super stranded patient numbers despite continued daily focus from the executive chief nurse and senior teams. We also experienced some discharge delays due to challenges with social care capacity in the community.

In March 2019, for the first time during the winter, our activity profile did not follow the predicted curve of the bed model as numbers of ED attendances and admissions continued to rise against a predicted reduction in activity. Attendances in March 2019 were 300 higher than in January 2019, and 600 higher than in December 2018. As a result all additional escalation and surge capacity was opened.

We have started reflecting on winter and further review will be undertaken with our system colleagues. But it is recognised that despite the significant challenges and exceptional demand our performance during winter was better than the same period last year. Planning and learning is already being put in place for next winter with patient flow identified as one of our three quality improvement priorities for the year.

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

  We have continued to experience reporting challenges from e-Care during 2018/19. Several technical fixes were installed during the year which increased the number of patients on the patient tracking list (PTL). During 2018/19 we also introduced the new access policy in line with the NHSI model. This was supported by a training programme for staff to improve data recording and quality.

  Despite the challenges we have seen a sustained reduction in patients waiting more than 52 weeks throughout the year. Overall 18-week performance during the year has remained stable but not achieved the planned improvements.

  Going forward a strategic review is being undertaken to understand the drivers behind the current performance and to inform service level action plans to deliver improvement. Key services where performance has deteriorated are working to deliver additional activity or find alternative providers. The plans being developed will support delivery of 90% against the standard.

- **Cancer standards**

  We have experienced challenges against four cancer standards during 2018/19. Some of this has been driven by increases in activity, for example referrals for suspected skin and breast cancer. We continuously strive to meet the cancer performance standards for all of our patients; for some standards the number of patients that we treat is small so small numbers of patients can have a large impact on the performance. We narrowly missed one standard by less than 0.5%. Changes in the allocation of shared breaches between providers during the year have contributed to this underperformance but following a review of our governance and processes we have now addressed this issue.

  The patient pathways for all cancers standards have been reviewed and improvements made to ensure timely and effective interventions.

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

  It is no small achievement that we met our financial control total for 2018-19, which in turn meant we received some additional funding from the national sustainability and transformation fund (STF). Our control total was set at a deficit of £13.8m before receipt of provider sustainability

funding (PSF). Against this target we delivered a deficit position of £13.5m, overperforming the plan by £0.3m.

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

Board assurance framework summary

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Quality of care	Quality or service failure, leading to reputation damage, reduced activity/income and/or regulatory action	Poor care and treatment of patients. Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Restricted authorisation / licensing by regulators
	Integration of community services as part of the Trust	Service quality and performance, financial viability and alliance stability
	Failure to work with local health and care system to manage emergency capacity and demand, including robust preparation for winter	Patient safety. Reputational impact and poor patient experience/satisfaction. Loss of provider sustainability funding. Negative impact on staff morale.
	Failure to deliver the national access standards	Poor care and treatment of patients. Loss of public and GP confidence. Negative impact on staff morale.
Environment, effectiveness and continuous improvement	Implementation of estates strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance incorporating the acute and community estate	Ageing building environment suitability for patient care which could lead to reputation damage and loss of income. Unknown financial impact if reputational consequences. Risk of improvement notices if fail to effectively maintain building(s). Ability to fund the capital programme
	Provision of sustainable pathology services	Impact on access to patient information to support patient care which leads to patient harm and/or increased delays. Withdrawal of service accreditation by regulators. Financial risk as part owner
	Failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of regulator licence (CQC and/or NHSI). Impact on cash flow. Inability to generate sufficient surplus to support capital investment. Reputational harm from adverse media coverage – loss of confidence
	Digital adoption, transformation and benefits realisation	Delivery risk to patient safety and the operational effectiveness of the Trust. Ability to report patient care and activity both timely and accurately. Quality, service and financial impact of failure to deliver planned improvements and benefits

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Workforce	Delivery of the workforce plan with an engaged and motivated workforce	Failure to achieve reduction of staff costs as part of financial plans. Quality and safety and reputation impact. Adverse employee relations and staff motivation. CQC regulatory action. Withdrawal of Royal College recognition. Impact of change upon staff morale and responsiveness including resistance may lead to impact upon current discretionary efforts of staff. Poor staff engagement hinders delivery of service change
Governance	External financial constraints impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or NHSI). Impact on cash flow and income and expenditure. Inability to generate sufficient surplus to support capital investment. Local position leads to tension between local health economy partners. Loss of provider sustainability funding to the local health system
	Development and delivery of the West Suffolk Alliance way of working as the local delivery unit for the STP	Ability to deliver safe and sustainable services for local population. Local position leads to tension between local health economy partners. Loss of provider sustainability funding to the local health system. Loss of confidence in WSFT and west Suffolk system

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which provide assurance to the Board that staffing processes are safe, sustainable and effective; including compliance with the 'Developing Workforce Safeguards' recommendations. These systems include:

- integrated quality and performance report (IQPR) and finance and workforce report - both reports are received at each public Board meeting. There 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 details 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 with 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 overseas the development of new roles to support sustainability within the labour market.

These arrangements are underpinned by director of nursing and medical director review, to ensure that effective systems are in place.

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

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the 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 a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

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

The board assurance framework provides evidence of the effectiveness of controls that manage the risks to the organisation achieving its principal objectives and that these have been reviewed. The annual governance statement is also informed by the latest CQC inspection report (January 2018).

The board assurance framework was reviewed and updated routinely during 2018/19 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for impact and likelihood. Analysis of key controls and assurances revealed that the Trust was managing its risks to a reasonable level, that the Board of directors was adequately informed of the effectiveness of control measures and that, where possible, appropriate corrective action was being taken to reduce identified high-level risks. This review identified that there were no major gaps in control or assurance, and Board reporting for areas with a high residual risk was sufficiently frequent.

The board assurance framework was subject to independent review by internal audit during 2018/19.

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 – which are subject to annual review and recommendations for improvement monitored through an agreed action
- Responsibilities of directors – directors objectives and performance are regularly monitored by the remuneration committee
- Responsibilities of subcommittees - are considered as part of the annual governance review and the quality and risk committee and audit committee provide an annual report to the Board on their activities and performance
- Reporting lines and accountabilities between the Board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the Board and executive team
- Submission of timely and accurate information to assess risks to compliance with the Trust's licence
- Degree and rigour of oversight the Board has over the Trust's performance – the Board continually reviews and develops its reporting arrangements to the Board. The monthly quality and performance report for the Board supports an open reporting culture and includes the results from the Friends and Family Test; the NHS safety thermometer, which covers falls and pressure ulcers, and infection control; and patient and staff experience surveys building up a picture of care quality on our wards. The range of indicators provides early warning of deterioration in performance and potential negative impact on quality. The finance and workforce report has been strengthened during the year including divisional reporting and performance against cost improvement programmes.

Information governance

The Trust's information governance assessment report overall score for 2018-19 was 40/40 assertions met. All 100 mandatory evidence items were provided. The Trust reported eight data breaches to the Information Commissioner's Office (ICO) in 2018/19. These incidents involved:

- Lost or stolen paperwork (1)
- Unauthorised access or disclosure (7)

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

Annual quality report

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

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 NHSI's well-led framework and its eight key lines of enquiry (KLOEs):

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

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

Scrutiny of the information contained within these indicators and its implication as regards patient safety, clinical outcomes and patient experience takes place at the Board as well as the quality and risk committee. There are a number of committees and executive groups with direct responsibility for key aspects of the quality agenda reporting to the quality and risk committee. The patient experience committee reviews the data from the patient experience surveys and provides feedback to the quality

and risk committee. The clinical safety and effectiveness and patient experience committees inform the quality and risk committee on relevant performance relating to the Trust's quality strategy and quality improvement plan. This is underpinned by quality walkabouts and continuous monitoring of defined quality indicators.

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

The Board is developing 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.

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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the audit committee and the quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of directors' role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. 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 in 2013, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the Board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Internal audit issued 17 reports relating to 2018/19; the 'opinion levels' are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	2
Substantial assurance - controls are suitably designed, consistently applied and operating effectively.	7
Reasonable assurance - identified issues that need to be addressed	5
Partial assurance - action is needed	3
No assurance - urgent action is needed	0

No internal audit reports were graded as red ('no assurance'). The conclusions from the three 'partial assurance' reports are set out below and action to address the concerns have been reviewed by the Audit Committee:

- **NE Essex and Suffolk pathology service (NEESPS)** – NEESPS' reporting does not provide the appropriate confidence that its solution will be delivered in a timely fashion, nor does it make clear the additional exposure to risk (and the necessary management of that risk) until delivery is complete. These factors, aligned to unclear decision-making accountabilities, could undermine efficient and effective progress towards accreditation and the resolution of quality issues
- **Annual leave management** – policies were found to be in place to clearly outline the process for managing annual leave with staff and managers aware of the processes in place. However, inconsistencies were found with the information in the policy documents and Healthroster, as the system has not been utilised robustly to capture annual leave entitlements and carry forward annual leave days which impacted on individual/department target and performance calculations
- **The Cambridge graduate course in medicine** - the audit identified a number of areas for improvement in the control framework to manage the 'Cambridge Graduate Course in Medicine' funds. Additionally, the Trust does not set a budget of how it intends to spend the funds throughout the year, and there is therefore no defined reporting against spend.

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

For the 12 months ended 31 March 2019, the head of internal audit's opinion for WSFT is that: "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

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

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

Conclusion

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

- **Pathology services**
  The pathology service delivered to the WSFT by North East Essex and Suffolk Pathology Services (NEESPS) has been a cause for concern during 2018/19 in terms of quality.

  The Medicine Healthcare Regulatory Authority (MHRA) undertook planned inspections of the blood transfusion service operated by NEESPS within the WSH during 2018/19 which highlighted some deficiencies with the service. The latest MHRA inspection, in February 2019, recognised that improvements have been made but identified that further work is required. We continue to work with East Suffolk and North Essex Foundation Trust (ESNEFT) as the host of NEESPS to address regulatory and accreditation concerns. We are also working with ESNEFT at a more strategic level to review the options for the networked provision of pathology services.

- **e-Care reporting and RTT performance**

  While much of our electronic patient record, called e-Care, has been a significant success we have continued to experience reporting challenges during 2018/19. This impacted on our reported referral to treatment (18-week) standard performance during 2018/19. Several technical 'fixes'

were installed during the year which increased the number of patients on the patient tracking list (PTL). During 2018/19 we also introduced the new access policy in line with the NHSI model. This was supported by a training programme for staff to improve data recording and quality.

Working with our digital partner, Cerner, we delivered significant improvements to reporting but control issues remained during 2018/19. We relied on estimated reporting during part of 2018/19 for the national standard for '18-week maximum wait from point of referral to treatment' and this is a cause for concern. Recovery of the patient tracking list (PTL) and reporting arrangements have been achieved but we continue to address the RTT activity challenge.

Plans are being finalised to recover 90% performance against the RTT standard during 2019/20.

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

Dr Stephen Dunn
Chief executive
28 May 2019

2.7 Remuneration report

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

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

The following parts of the remuneration and staff report are subject to audit: single total figure table of remuneration for each senior manager, pension entitlement table and other pension disclosures for each senior manager, fair pay disclosures, staff report: exit packages, staff report: analysis of staff numbers, and staff report: analysis of staff costs.

Annual statement on remuneration

There was one new appointment to executive roles during 2018/19 - the executive chief operating officer was appointed in May 2018. Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses.

Senior managers' remuneration policy

Senior managers' pay consists of the following elements:

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

Remuneration Committee

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

- advise the Board about appropriate remuneration and terms of service for the chief executive, other executive directors and other senior employees including:
  - all aspects of salary (including any performance-related elements/bonuses)
  - provisions for other benefits, including pensions and cars
  - arrangements for termination of employment and other contractual terms
- make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff
- scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate, advise on and oversee appropriate contractual arrangements for such staff
- monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including:
  - establishing the objectives of the chief executive and review the performance of the chief executive against these objectives
  - scrutinising the objectives of the executive directors (to be established by the chief executive) and review performance reports on the executive directors prepared by the chief executive

- scrutinise the recommendations of the Clinical Excellence Awards Committee
- review the terms of reference of the committee every two years
- report the frequency of meetings and the members of the Remuneration Committee in the Trust's annual report of the Trust
- the committee shall report in writing to the Board the basis for its recommendations.

The committee comprises the chairman and NEDs of the Board of directors. The committee is chaired by a non-executive director (Mr A Eaton). 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 NEDs. A nominated representative for the chair must be a NED.

The committee acts with delegated authority from the Board of directors and will usually meet at least annually. Minutes are taken and a report submitted to the Board of directors showing the basis for the recommendations. Three meetings of the committee were held during 2018/19. All non-executive directors were in attendance for both meetings with the exception of: Mr. S Turpie who was unable to attend the meeting held in April 2018; and Ms L. Pepper who was unable to attend the meeting held in November 2018.

Senior managers' (executive directors') pay is annually reviewed by the remuneration committee. The committee is presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS market in the context of pay awards to other staff groups. Decisions to uplift salaries are based on this information, internal equity, affordability, whether there has been a significant change in a director's portfolio and thus responsibility. Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable, including any senior manager paid more than £150,000. In addition, each director can receive the NHS cost of living pay rise which is based on the national NHS pay award. In recent years the Department of Health has advised the chair on the expected level. The arrangements for managing the remuneration policy for senior managers was strengthened during 2018/19 to include engagement with staff and public governors.

The Trust does not have a performance related pay scheme. The committee, however, has the delegated authority to pay one off discretionary payments in exceptional circumstances. The chief executive presents an annual report on executive directors' performance (in the case of the chief executive this is presented by the chair) based on the outcome of their annual appraisal.

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.

Policy on payment for loss of office

Approval for any non-contractual severance payments should be obtained from the remuneration committee and NHSI following submission of a business case. In respect of individuals earning over £100,000, any severance payment should include a provision requiring the repayment of the severance payment where the individual returns to work for the NHS in England within 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 un-expired element of his/her compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary.

Annual report on remuneration

In the financial year the directors' costs increased to £1,191k from £1,111k. There were no exit packages paid to Board members in the 2018/19 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.

	2018/19		2017/18	
	Directors	Governors	Directors	Governors
Total number in office during the year	13	26	15	36
Total number receiving expenses	6	7	6	10
Aggregate total of expenses paid during the year (£)	9,134	1,525	16,010	1,986

Fair pay disclosure

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

The banded remuneration of the highest paid director in the Trust in the financial year 2018/19 was £180k- £185k (2017-2018, £165k - £170k). This was eight times (2017/18, seven times) the median remuneration of the workforce, which was £23,951 (2017/18, £24,547). This is calculated based on all staff employed and salaries as at 31 March 2019.

In 2018/19, one employee (2017/18, nine employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £17,460 to £202,819 (2017/18 £15,362 to £249,218).

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.

There are no additional benefits that will become receivable by a director in the event of early retirement.

Table A – Remuneration

Name and title	Year to 31 March 2019				Year to 31 March 2018				
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	Increase in pension entitlement (bands of £2500)	Total (bands of £5000)	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	Other Expenses to nearest £100	Increase in pension entitlement (bands of £2500) *	Total (bands of £5000) *
	£000	£	£000	£000	£000	£	£	£000	£000
Mrs H Beck - chief operating officer (note 1)	110 - 115	1,700	112.5 - 115	225 - 230	90 - 95	-	-	150 - 152.5	240 - 245
Mr C Black – executive director of resources	135 - 140	7,100	52.5 - 55	195 - 200	125 – 130	6,600	-	35 - 37.5	170 - 175
Ms J Bloomfield – executive director workforce and communications	105 - 110	200	120 - 122.5	230 - 235	95 – 100	300	-	50 - 52.5	150 - 155
Mrs S Childerhouse - chair (note 2)	45 - 50	-	-	45 - 50	10 - 15	-	-	-	10 - 15
Dr R Davies - non executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	-	10 - 15
Dr S Dunn – chief executive	175 - 180	9,400	82.5 - 85	270 - 275	165 - 170	6,700	-	100 - 102.5	270 - 275
Mr A Eaton - non executive director (note 3)	10 - 15	-	-	10 - 15	0 - 5	-	-	-	0 - 5
Mr J Green - chief operating officer (note 4)					5 - 10	-	-	2.5 - 5	10 - 15
Mr N Hounsome - non executive director (note 5)					5 - 10	-	-	-	5 - 10
Dr N Jenkins - medical director (note 6)	175 - 180	-	47.5 - 50	225 - 230	165 - 170	-	8,000	142.5 - 145	315 - 320
Mr G Norgate – non executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	-	10 - 15
Mrs L Pepper - non executive director (Note 7)	5 - 10	-	-	5 - 10					
Ms R Procter – executive chief nurse	120 - 125	-	52.5 - 55	170 - 175	110 - 115	-	-	32.5 - 35	140 - 145
Mr R Quince – chair (note 8)					30 - 35	-	-	-	30 - 35
Mr A Rose - non executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	-	10 - 15
Mr S Turpie – non executive director (note 9)	0 - 5	-	-	0 - 5	10 - 15	-	-	-	10 - 15

* Restated to take account of employees contribution to pension

No additional performance pay and bonuses were paid in 2018/19 or 2017/18.

Table B – Pension benefits to 31 March 2019

Name	Real increase / (decrease) in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash equivalent transfer value at 1 April 2019	Real increase / (decrease) in cash equivalent Transfer Value	Cash equivalent transfer value at 31 March 2018
	£000	£000	£000	£000	£000	£000	£000
Mrs H Beck	5 - 7.5	15 - 17.5	35 - 40	115 - 120	979	206	750
Mr C Black (Note 11)	2.5 - 5	2.5 - 5	40 - 45	100 - 105	751	133	597
Ms J Bloomfield	5 - 7.5	10 - 12.5	50 - 55	150 - 155	1158	190	939
Dr S Dunn (Note 10)	5 - 7.5	0	65 - 70	0	869	177	667
Dr N Jenkins (Note 11)	2.5 - 5	0 - 2.5	35 - 40	75 - 80	551	112	426
Ms R Procter (Note 11)	2.5 - 5	2.5 - 5.0	25 - 30	60 - 65	470	103	356

Notes

1. H Beck started as Interim chief operating officer May 2017 and appointed as substantive chief operating officer May 2018
2. S Childerhouse was appointed as chair in January 2018
3. A Eaton started as a NED in January 2018
4. J Green left May 2017
5. N Hounsome left December 2017
6. N Jenkins was appointed as medical director November 2016. His remuneration includes payments for clinical sessions
7. L Pepper started as a NED in September 2018
8. R Quince left December 2017
9. S Turpie left May 2018
10. Lump sum is zero as a member of 2008 Section and 2015 Section which does not provide an automatic lump sum
11. Lump sum increase may be zero or low as now a member of 2015 Scheme which does not provide an automatic lump sum

Dr Stephen Dunn
Chief executive
28 May 2019

2.8 Staff report

2.8.1 Our staff

The Trust is one of the largest employers in the west of Suffolk, employing 4,045 staff as of March 2019. It firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2018/19 with the following activities:

- The 2018 national staff survey confirmed WSFT as one of the best performing in country for: staff having a choice in deciding how to do their work, and staff not feeling pressure from their manager to come to work, when not feeling well. Based on Health Service Journal analysis WSFT was best in the East of England and 4th in the country for staff recommending the Trust as a place to work and receive treatment
- A Freedom to Speak Up Guardian for the Trust, and Safe Working Guardian for junior doctors, continue to support our open and inclusive culture
- Staff governors also continue to support staff to discuss challenges and achievements and report back on these
- As part of the Trust's health and wellbeing programme we continue to focus on mental health and wellbeing, by offering mental health awareness sessions for managers, Care First (a telephone help-line for all health and wellbeing issues) and various wellbeing options, such as a mindfulness app
- Staff continue to receive financial assistance in the form of low interest loans which are arranged by an external organisation, and have access to an onsite occupational health service, including a physiotherapist, counselling and flu vaccinations
- Staff have the opportunity to join local gyms at a discounted rate
- My Wish Charity, which supports West Suffolk Hospital, continues to support the health and wellbeing programme of the Trust including the dog show and country fair
- An active flu campaign improved the uptake of the flu vaccine among staff (2018/19: 75.1%; 2017/18: 71% and 2016/17: 65%)
- We have continued to support the trade union convenor role
- We continue to develop our partnership working through the following committees:
  - Trust council
  - Trust negotiating committee (general staff)
  - Trust negotiating committee (medical and dental)
  - Travel plan steering group
  - Health and wellbeing steering group.

2.8.2 Staff costs

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	130,667	170	**130,837**	119,784
Social security costs	12,984	-	**12,984**	11,832
Apprenticeship levy	635	-	**635**	579
Employer's contributions to NHS pensions	15,595	-	**15,595**	14,146
Pension cost - other	31	-	**31**	-
Termination benefits	-	-	**-**	53
Temporary staff	-	5,188	**5,188**	4,905
Total staff costs	**159,912**	**5,358**	**165,270**	151,299
Of which				
Costs capitalised as part of assets	2,544	692	**3,236**	3,514

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

	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	415	46	**461**	427
Ambulance staff	-	-	**-**	-
Administration and estates	712	45	**757**	719
Healthcare assistants and other support staff	701	89	**790**	748
Nursing, midwifery and health visiting staff	971	94	**1,065**	1,019
Scientific, therapeutic and technical staff	529	9	**538**	497
Total average numbers	**3,328**	**283**	**3,611**	3,410
Of which:				
Number of employees (WTE) engaged on capital projects	56	0	**56**	68

2.8.4 Reporting of compensation schemes - exit packages 2018/19

There were no compensation schemes - exit packages in 2018/19. There were three compensation schemes - exit packages in 2017/18, with a total resource cost of £55,000. There were no non-compulsory departure payments in 2018/19 and none in 2017/18.

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

	Male	Female	Total
Executive directors (including CEO)	3	3	6
Non-executive directors (including Chair)	2	4	6
Other senior managers (band 8d and above)	7	4	11
Employees	752	3,270	4,022

2.8.6 Sickness absence data

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

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
3,315	29,157	8.8	1,209,944	47,299

Source: NHS Digital Statistics

Data items: the electronic staff record (ESR) does not hold details of normal number of days worked by each employee. (Data on days lost and days available produced in reports are based on a 365-day year). The number of FTE-days available has been estimated by multiplying the average FTE for 2018 by 225. The number of FTE-days lost to sickness absence has been estimated by multiplying the estimated FTE-days available by the average sickness absence rate. The average number of sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average

FTE. Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff.

2.8.7 Trade Union facility time information

Number of employees who were trade union officials	Whole time equivalent
33	32
Percentage of time spent on facility time	**Number of employees**
0%	17
1%-50%	15
51% - 99%	1
100%	0
Total cost of facility time	**Costs**
	£22,397
Total pay bill	£165,905,000
Percentage of pay bill spent on facility time	0.0135%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
205 hours activities	17.96%

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; as evidenced by our strategic framework *Our patients, our hospital, our future, together*'.

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.

Our **inclusion strategy objectives** are:

- For **patients, service users and carers**:
  - Improve the patient experience and care of older age patients (including those with dementia).

- For **staff**:
  - Promote and support inclusive leadership at all levels of the Trust
  - Ensure the recruitment interview process is bias free
  - Establish diversity network groups to provide a forum for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the Trust
  - Close the gender pay gap.

- For **patients, service users, carers and staff**:
  - Promote a culture of inclusion in delivery of care to all patients and staff
  - Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
  - Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours
  - Embed equality and inclusion in mainstream business processes.

Our objectives have been drawn from an in-depth analysis of progress to date with our equality delivery system (EDS), a review of EDS2 goals and outcomes, a review of our performance against the nine Workforce Race Equality Standard indicators, national staff survey results, our gender pay

gap report, the Trust's strategic framework '*Our patients, our hospital, our future, together'* and the requirements of the Equality Act (2010), including the Public Sector Equality Duty (PSED).

Our objectives will be reviewed and updated for the two year period August 2019 to July 2021. Progress is monitored quarterly by the equality and diversity steering group and an annual report is received by the Board.

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

Employees and public members protected characteristics

	Staff in post			Public Members		
	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17
Age						
16	0	0	0	0	0	1
17-21	64	49	61	51	65	34
22+	3,981	3,765	3,597	5,800	5,854	5,963
Not Specified	0	0	0	123	126	170
Total	4,045	3,814	3,658	5,974	6,045	6,168
Ethnicity						
White	3,382	3,182	3,078	5,331	5,391	5,565
Mixed	44	40	37	29	28	28
Asian or Asian British	312	264	263	88	90	72
Black or Black British	31	27	22	23	23	23
Other ethnic group	42	39	36	30	30	69
Not Stated	213	257	66	473	483	411
Undefined	21	5	156	0	0	0
Total	4,045	3,814	3,658	5,974	6,045	6,168
Gender						
Female	3,281	3,111	2,966	3,673	3,684	3,716
Male	764	703	692	2301	2361	2452
Total	4,045	3,814	3,658	5,974	6,045	6,168
Disability						
No	1,770	1,557	1,387	-	-	-
Not declared	327	356	286	-	-	-
Undefined	1,276	1,798	1,897	5,338	5,386	5,434
Prefer not to answer	558	-	-	-	-	-
Yes	114	103	88	636	659	734
Total	4,045	3,814	3,658	5,974	6,045	6,168

Source: Electronic Staff Record (as at 1/4/2018).

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 and will develop a plan based on performance against the new NHS Workforce Disability Equality Standard in 2019/20.

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 who then escalates any issues of concern to the corporate risk committee. Both of these committees meet quarterly. Issues that cannot be resolved or which need to be escalated are reported up to the trust executive group and the Board of directors accordingly.

Risk assessment

The strategy for the management of risk within WSFT continues to be developed and promoted Trust-wide. The Datix risk register is a tool for capturing, prioritising and managing the significant risks and is integral to the Trust's risk management framework.

The risk register allows all divisions to manage, monitor and review their own risks. The responsibility lies with each departmental manager to ensure all of their operational and corporate risks are captured on the risk register. Risk register training is provided by the health, safety and risk manager and the risk officer.

Between April 2018 to March 2019, 31 members of staff were trained in the principles of health, safety and risk assessment. This has improved the quality and quantity of risk assessments and has helped to promote the use of the risk register.

Workplace inspections are undertaken by health and safety link persons who are qualified with the RSPH Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. 189 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 2018 to March 2019 a total of 26 incidents were reported to the Health and Safety Executive (HSE) as required under RIDDOR. This is an increase of one from the previous year.

There were no RIDDOR reportable incidents for being struck by a falling or moving object or from a needlestick incident. There was a slight decrease in the category of 'moving and handling' (from ten to nine incidents); although this remained the highest reporting category. There was an increase in the category of 'violence and aggression' (from two to five incidents).

RIDDOR description	2018/19
Moving and handling incidents	9
Violence and aggression	5
Health and safety incidents	5
Slips, trips and falls	6

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

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

Of the 26 incidents reported to the HSE, 19 incidents (73%) were due to being off work for more than seven days following an incident. The health and safety committee reviews incident trends, including RIDDORs to ensure that appropriate learning takes place and action is taken.

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 2018 to March 2019 there were 229 violence, abuse and harassment incidents - a increase of 62 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 229 incidents reported there were 76 physical assaults, and 64 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, the patient is suffering from dementia or is cognitively impaired. During 2017 new training to support staff in managing challenging behaviour was introduced.

There were 1,568 reported incidents of personal accident/ill-health during 2018/19. This is an increase of 45 incidents (3%) 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 3 (quality report).

2.8.10 Occupational health report / occupational health and wellbeing service

Occupational health and wellbeing vision:

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

Cambridge Health at Work (CHaW), working in special partnership with WSFT, provides a full range of occupational health services. The service continues to strive to improve quality and effectiveness by working with teams and specialties across the organisation. CHaW is accredited and is the only training centre in the region for occupational health physicians. Working closely with CHaW, our focus is on ensuring those who work for WSFT are safe, healthy and productive in their work. The CHaW team continue to support WSFT with achieving the staff health and wellbeing commissioning for quality and innovation (CQUIN), derived from the NHS Five Year Forward View. Working in partnership and sharing expertise, we continue to provide a tailored programme for staff; reduced the promotion of food high in sugar and fat sold on the premises; and achieved 71% uptake of the flu vaccination by the WSFT workforce, which includes community colleagues.

We have already begun planning for the flu campaign for winter 2019-20 and believe we will achieve the uptake target. The CHaW online resources (website supported by extensive social media engagement) of information and sign-posting for staff continue to be well received. We have also seen very positive use of the Trust's employee assistant programme (EAP) provided by our partner Care First. The EAP delivers 24/7 telephone advice and counselling service, face to face counselling, support following a major traumatic event and an information service on legal, financial and social matters.

We are delighted to have introduced a dedicated wellbeing coordinator to help facilitate and coordinate all of the initiatives now in place and new exciting opportunities we hope to capitalise on in

the coming year. Working closely we are committed to delivering the WSFT health and wellbeing strategy and a programme of improving and protecting the health of our workforce.

2.8.11 Staff survey

The following report includes commentary of the national staff survey (2018). It contains details on staff engagement and survey response rates, best and worst ranking scores, the key 10 indicators and future priorities.

Staff engagement

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

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

- The core brief – monthly briefing cascade
- Monthly team briefings
- Freedom to Speak up / Freedom to Improve
- Exec weekly drop-ins
- Exec and environmental walkabouts
- Weekly staff briefing
- Monthly medical staff bulletin for consultants and junior doctors
- Staff conversation events – facilitated by staff governors
- The weekly staff newsletter, ‘Greensheet’ and weekly ‘Staff Briefing’ email
- The Buzz – an electronic community communication area via the intranet
- Quality leadership events
- InfoX – a confidential electronic channel to raise issues and concerns
- Five o’clock Club (leadership talk forum)
- The ‘Bright Ideas’ scheme
- Staff awards – annual ‘Shining Lights’ awards, monthly ‘Putting you First’ award, new Trust thank you cards, and ‘The David Dumbleton Porter of the Year award’ recognising the WSFT porter of the year
- Staff health and wellbeing group
- Staff engagement on corporate social media, e.g. Twitter and Facebook.

Summary of staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions, with the indicator score being the average of those.

The response rate of the 2018 survey among Trust staff was 48.4% (2017: 47.9%). Scores for each indicator together with that of the survey benchmarking group of acute trusts are presented below.

Indicator	2018/19		2017/18		2016/17	
	Trust	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	**9.3**	**9.1**	9.2	9.1	9.3	9.2
Health and wellbeing	**6.4**	**5.9**	6.5	6.0	6.4	6.1
Immediate managers	**7.0**	**6.7**	6.8	6.7	6.9	6.7
Morale	**6.4**	**6.1**	No data available as new indicator			
Quality of appraisals	**5.5**	**5.4**	5.2	5.3	5.0	5.3
Quality of care	**7.6**	**7.4**	7.7	7.5	7.6	7.6
Safe environment – bullying and harassment	**8.1**	**7.9**	8.2	8.0	8.0	8.0
Safe environment – violence	**9.4**	**9.4**	9.3	9.4	9.4	9.4
Safety culture	**7.0**	**6.6**	7.0	6.6	6.9	6.6
Staff engagement	**7.4**	**7.0**	7.4	7.0	7.4	7.0

Best and worst scores against benchmarking

Best scores

Indicator	2018/19		2017/18		2016/17	
	Trust	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
I have a choice in deciding how to do my work. Q6b	**61.1%**	**54.0%**	No data available as new score			
Have you felt pressure from your manager to come to work? Q11e	**19.1%**	**25.9%**	25.6%	26.7%	24.6%	27.1%

Worst scores

Indicator	2018/19		2017/18		2016/17	
	Trust	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
The last time you experienced physical violence at work; did you or a colleague report it? Q12d	**49.7%**	**65.6%**	65.2%	66.4%	68.4%	67.2%
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? Q13d	**37.9%**	**44.2%**	51.2%	45.0%	51.1%	45.1%
The last time you saw an error, near miss or incident that could hurt staff or patients / service users, did you or a colleague report it? Q16c	**91.4%**	**95.0%**	90.1%	94.7%	95.7%	94.8%

Summary of staff survey response

The following summaries provide details on the response rates to the recent staff survey and how this compares to the previous years.

	2018/19	2017/18	2016/17
Response rate	**48.4%**	47.9%	50.1%
Benchmarking group	**44.4%**	44.2%	42.8%

Future priorities and targets

The key priority areas identified from the survey are:

- **Reporting** – How do we improve on staff members reporting incidents, so as to be in-line with other organisations?
- Creating a **compassionate and inclusive culture,** being kind to each other – dealing with bullying and harassment, improving equality and inclusion
- Improving **visible leadership** to ensure that staff feel valued and engaged.

The actions identified include:

- Discussions will be facilitated with each division with the expectation that the division contributes ideas for each of the above priorities for improvement. The improvements will be monitored at divisional performance meetings
- Consider how to increase the 2019 completion rate, especially for medical staff and nursing assistants. Identify actions and monitor completion of 2019 survey
- Summer leadership summit will start the discussions around agreeing action to improve patient safety, staff satisfaction and wellbeing creating a more inclusive culture and improving everyone's experience at work, and to make sure all staff have the freedom to speak up and improve. Monitored through trusted partners activity, staff supporters and other networks
- Trust executive group (TEG) to discuss the actions needed to improve visibility and actions of senior leaders.

2.8.12 Pension liabilities for ill-health retirement

There was one ill-health retirement during the year to 31 March 2019 (2018: one); the additional pension liability borne by NHS Pensions was estimated as £14k (2018: £70k).

2.8.13 Policies and procedures for fraud and corruption

The Trust is committed to the elimination of fraud and corruption. The Trust is determined to protect itself and the public from such unlawful activities, whether they are attempted from within the Trust, or by an outside individual, group or organisation.

The Trust is committed to ensuring that opportunities for fraud and corruption are reduced to the lowest possible level by creating an anti-fraud culture that:

- deters fraud
- prevents fraud that cannot be deterred
- detects fraud that cannot be prevented.

To achieve this WSFT will:

- ensure that employees, contractors, suppliers and users of our services understand that fraud is unacceptable and that they are able to raise serious concerns easily
- share information with other trusts and organisations to deal with fraud and corruption locally and nationally, working within the law
- increase awareness of fraud and corruption through a programme of training and communication
- investigate all allegations of fraud and corruption in a professional manner

- apply appropriate sanctions such as disciplinary action, criminal proceedings and recovery of losses when necessary. Where appropriate, WSFT will publicise cases demonstrating the Trust's commitment to fighting fraud.

By creating an anti-fraud culture, the Trust will help ensure that money is not lost to the organisation that could have been invested in patient care. It will also provide an environment in which employees have the confidence to report any fraud concerns they may have.

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

2.8.14 Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of March 2019	7
Of which:	
No. that have existed for less than one year at the time of reporting.	2
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.	1
No. that have existed for between three and four years at time of reporting.	3
No. that have existed for four or more years at time of reporting.	1

For all new off-payroll engagements or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	2
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/ assurance purposes during the year	7
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

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.	26

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

The Trust has reviewed off payroll arrangements and from 6/4/17 all arrangements have been terminated or moved to payroll unless they are assessed as meeting HMRC's requirements to be paid gross. There were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

During 2018/19, the Trust spent £153k on consultancy costs (2017/18 £2,587k). 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.

3. Quality report

3.1 Chief executive's statement

I am delighted to introduce this year's quality report on behalf of the West Suffolk NHS Foundation Trust (WSFT).

In the NHS we talk about quality a great deal; quality of care, quality outcomes, quality of support for staff, quality improvements, and quality of learning when we get things wrong. In fact it underpins our Trust vision – to deliver the best quality and safest care for our community – and each of our Trust values (focused on patients; integrated; respectful; staff focused; two-way communication) supports a culture driven by quality.

You'll be able to read more about what we've achieved, what we still need to improve on, and our quality ambitions for the coming year in this report, but I want to touch upon some elements here. As a Board we will always make our decisions based on what we think will help provide the best quality of care to our patients, and we're incredibly lucky that that ethos is also reflected in our 4,500+ staff and volunteers.

We can only achieve what we do because of our people - our amazing outcomes are unpinned by our staff and our diversity, and through their incredible efforts this year we've made some huge quality improvements.

We've invested in state-of-the-art facilities; our new £5.2m cardiac suite, which was supported with a staggering £500,000 from our My WiSH Charity, has transformed the quality of heart healthcare we can provide to our community. For the first time we can offer additional procedures like angiography and pacemakers to patients - meaning better care and reduced waiting times for patients and reduced pressure on other centres where patients were once referred.

The year has also seen us deliver the first stage of our acute assessment unit (AAU), which is transforming how we assess and treat emergency patients.

The AAU model is designed to support emergency patients that need observation, diagnosis and treatment, but who don't need major emergency department care – for example, patients with chest pain who may need a heart monitor and clinical observation. The goal of the AAU is to assess patients quickly; the unit will diagnose the patient's condition, and wherever possible treat them the same day so they can return home with the help they need, like take-away medications. Having had observations and monitoring done on the unit, those patients who do need ongoing care in hospital can then be transferred to the right, specialist ward for their needs first time.

The unit, which contains assessment and monitoring trolleys and specialist chairs instead of hospital beds, is helping to ease pressure on the emergency department – leaving it to just care for those with major conditions, or minor injuries that can be treated quickly.

And our quality improvements will continue across the coming year, not least with the December announcement that we've been allocated £13.4m to upgrade our emergency department. The changes we have planned will also enhance and modernise the department, separate ambulance arrivals from other patients needing major and minor services, and reduce turnaround time for ambulances, meaning patients are treated faster.

We're improving quality through innovation too; we're in the process of introducing Medic Bleep, an app to replace physical non-emergency bleeps across the Trust. Medic Bleep allows hospital and community staff to communicate in real time, sharing vital information and updates about patients accurately and safely. Whilst not a replacement for face-to-face communication, the new technology is considered far more effective than the pager system which is common in most hospitals, and in our

pilot saved junior doctors an average of 48 minutes per shift, and nurses 21 minutes. This frees up time for our staff to do what they do best – care for our patients.

And our digital quality improvements don't end there; this year we went live in a UK first with Cambridge University Hospitals NHS Foundation Trust (CUH), in the form of a technical breakthrough which links the two trusts' electronic patient record (EPR) systems. At the push of a button, clinicians are now able to easily and securely access clinical information on a patient that is held within the other trust's EPR system – Epic at CUH (Addenbrooke's and The Rosie hospitals) and Cerner Millennium at West Suffolk Hospital – to enhance patient care.

Currently available in the accident and emergency department of Addenbrooke's Hospital and at West Suffolk Hospital, clinicians can access information in this real-time digital way if a patient has been treated at the opposite hospital within a 12-month period, a common occurrence given the hospitals' proximity. So from within each hospitals' EPR systems clinicians can see a patient's past and present clinical information - from conditions and treatments to latest test results held at the opposite hospital - saving time and reducing delays to care and duplication.

Our teamwork with other partner organisations is extending in other remits too; we're looking at how we can collectively capture population health data in our community so that we can better focus on prevention, and through our close working with other health and social care organisations in August we were delighted to be announced as the best performing area in the country for minimising the amount of time patients stay in hospital longer than is necessary.

Figures from NHS England show the NHS West Suffolk Clinical Commissioning Group (CCG) area has fewer excess bed days – the term used to describe where people are still in hospital when they no longer need to be there – for its size of population than any of the other 194 CCGs in the country. In 2017 there were 12.2 excess bed days per 1,000 population in west Suffolk, against a national average of 37.8.

And our partnership working has even moved into international fields in the interest of quality and shared learning – we have a clinical learning programme with RAF Lakenheath's 48th Medical Group that allows U.S. Air Force (USAF) colleagues to bolster their experience in an NHS environment.

The scheme sees military medics support NHS staff in operating rooms, the emergency department and critical care units. This helps them sustain and improve their high-level clinical skills and allows the Trust to benefit from the help of additional medical personnel. This is a long-term partnership that we're very proud of, with regular rotations throughout the year. It's a really important programme, we're committed to it and are pleased the rotations on offer have grown over the duration of the partnership; it supports positive patient care and outcomes. Since January 2016, nearly 700 surgical procedures have been performed by USAF surgeons at West Suffolk Hospital.

All of these things go hand-in-hand with our clinical quality outcomes – the bread and butter of what we doing in making sure the patients we care for get the best treatment and care we can offer.

It has not been easy; you will find more information in this report about our challenges with meeting some national standards this year, including the four-hour emergency access and referral to treatment standards. We were better prepared for winter than we've ever been before, but it was still incredibly pressured. Demand increased yet again, and at points we had to open all our available escalation areas to care for the sheer number of patients who needed our care.

As a result our staff have really felt significant pressure. We have often had to move colleagues from one ward to another in order to ensure that we have enough staff to run a ward at a level we consider safe. Whilst we are actively recruiting and have more nurses than ever before, we know we still need more people on the ground and that the NHS nationally is struggling with this same challenge.

It has been a challenging 12 months, and no one here at WSFT is under any illusion that the coming 12 months will be any less so. But I know that I, and our incredible, hard-working, dedicated staff

without whom none of these achievements would be possible, will continue to deliver high-quality patient care to the best of our ability – 24/7, 365 days a year.

I can confirm that to the best of my knowledge the information contained in the quality report 2018/19 is accurate and has received the full approval of the Trust Board.

Dr Stephen Dunn
Chief executive
28 May 2019

3.2 Quality structure and accountabilities

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

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

The Board monitors quality through its **performance management arrangements** on a monthly basis. The Board also receives assurance regarding quality within the organisation through the quality and risk committee and its three subcommittees, which ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare. The subcommittees are:

(a) **Clinical safety and effectiveness committee** – ensuring clinical procedures and practices are effective in protecting patients, visitors and staff. This is achieved through reviewing compliance with national requirements, promoting best practice and ensuring effective identification and elimination or reduction of clinical risk

(b) **Corporate risk committee** – ensuring risk management, financial and workforce procedures are effective in promoting good business standards, protect the organisation, patients, visitors and staff, and comply with national standards and guidance

(c) **Patient experience committee** – ensuring exemplary customer and patient experience through the implementation of the improvement strategy and Patients First initiative.

3.3 Quality improvement priorities for 2019/20

The quality priorities for 2018-20 were identified by asking our specialists, listening to what our partners and community tell us, and looking outwards for how we can help other organisations achieve their own goals. Following a consultation exercise which led to 70+ proposals for improvement activities, an initial 18 headline subjects were picked for 2018-20, badged against the Trust priorities to progress with targeted support from the quality improvement (QI) team (made up of subject experts and trained QI coaches). All other suggestions were acknowledged as worthy of local improvement activity but not necessarily highlighted for central support.

One year into this programme a review has highlighted major progress in many areas. Some of these have been deemed more appropriate to be managed through Trust 'business as usual' operational processes. In the second year of the programme we have set the quality priorities at a higher level with the expectation that projects across the Trust will form **part of the coordinated programme** to support their delivery.

1. Patient flow

Why a priority

The Trust has made significant improvement to patient flow through a range of initiatives and focus on improvement; this includes the introduction of 'Red2Green' and 'SAFER' onto all adult inpatient wards. The recent challenge of winter has highlighted the importance of maintaining this focus and ensuring that all recommended processes are fully embedded across the Trust. The transformation team is leading a planned ward-by-ward review of the initiatives, reviewing to what extent they are embedded and offering support to the ward staff. We will also take the opportunity to add any new initiatives which will support patient flow within the hospital and community ahead of winter 2019/20.

What are we trying to achieve

- Embed the Red2Green and SAFER processes across the organisation to ensure patients' time is valued, while making the best use of the resources available
- Patients who no longer require an acute hospital bed are supported to achieve a timely, safe and informed transfer of care
- Working with system partners to ensure we maximise the benefits of alliance working across the localities.

Measurement

- Medication management – earlier completion of patient to take out (TTO) medication during the day
- Patient discharges:
    - increase discharges before 10am, 1pm and 3pm
    - sustained increase in weekend discharges
- Maintain reduction in super-stranded patient numbers (patients who remain in hospital after being medically optimised for more than 21 days)
- Timely completion of discharge summaries
- Responsive care – completion of the discharge readiness on white boards
- Discharge to optimise and assess 'Pathway 1' - patient assessment in their own home
- 'Pathway 3' for patients with delirium: try to get patients home in an appropriate environment close to home
- End-of-life fast track data
- Patient engagement in discharge process – measure through internal FFT.

2. Human factors

Why a priority

Research, case studies and national guidance illustrate how implementing the consideration of human factors in healthcare can reduce harm and improve both patient and staff safety, providing invaluable insights for all concerned with clinical quality.

What are we trying to achieve

- Make it hard for mistakes to happen – using both staff and systems approaches
- The aim of the quality priority is to increase human factors use across the Trust to reduce harm to patients and staff as a result of human factors
- To broaden understanding amongst our healthcare teams of the potential ways in which human factors methods can be applied to improve patient and staff safety
- To reinforce the importance of an open and transparent culture and a just culture, where no one is afraid to speak up
- To increase the board to ward and support services awareness of the potential for failure, so that speaking up is encouraged
- Share practical experience of applying human factors in healthcare, using case studies from different care settings
- Signpost healthcare teams to further information and resources to support them to implement human factors in their own team and departments.

Measurement

- Carry out a baseline Trust-wide patient safety culture questionnaire
- Develop a human factors section of the Trust's patient safety strategy
- Expand human factors training faculty to represent all of the Trust
- Offer human factors training to all staff groups across the Trust, clinical and non-clinical
- Embed human factors thinking into incident investigations and share lessons across the system
- Work with the staff across the Trust to identify measures to support a just culture for staff.

3. Quality improvement (QI)

Why a priority

In 2018 WSFT co-designed a quality improvement framework with staff, to implement a structured approach to the use of quality improvement methods to drive continuous improvement in quality and outcomes throughout the Trust. One year on, we are making quality improvement a quality priority to accelerate dissemination and adoption of improvement science knowledge, skills and application.

What are we trying to achieve

- A culture of continuous quality improvement using a recognised, evidence-based method (the Institute of Healthcare Improvement's Model for Improvement)
- Capacity and capability to apply the model for improvement in all teams and departments throughout the Trust
- Demonstrable improvements in quality across all six domains (effectiveness, safety, experience, access, efficiency and equity) as a result of applying the model.

Measurement

- Deliver a tiered training curriculum so that improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change. This will be approached on a system basis. Goal over three years is 250 people receiving foundation training and 60 people trained as QI coaches
- Use of LifeQI online platform for planning, managing and recording quality improvement projects
- Successful rebrand of Freedom to Improve
- Portfolio of QI projects demonstrating adoption of model for improvement in all divisions and all professional groups, with measureable impact on the quality of care we deliver
- Learning from improvement work has been shared at local, regional and national level

3.4 Statements of assurance from the Board

This section of the quality report is prescribed by regulation. It provides a series of mandated statements from the Board which directly relate to the drive for quality improvement. These statements provide assurance in three key areas:

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

Review of services

During 2018/19, WSFT provided and/or sub-contracted **65 relevant health services**. WSFT has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 was **£200.2m**, which represents **83.7% of the total income** generated from the provision of relevant health services by WSFT for 2018/19.

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

Table A: Sources of quality intelligence

Deliver personal care	Deliver safe care

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

Participation in clinical audits and confidential enquiries

During 2018/19, 49 national clinical audits and seven clinical outcome review programmes covered NHS services that WSFT provides.

During 2018/19, WSFT participated in 98% of national clinical audits and 100% of clinical outcome review programmes which it was eligible to participate in.

The national clinical audits and clinical outcome review programmes that WSFT participated in, and for which the data was completed during 2018/19, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry listed in Annex A.

The reports of nine national clinical audits and 46 local clinical audits were reviewed by the provider in 2018/19 and WSFT intends to take the actions detailed in Annex A to improve the quality of healthcare provided.

Research and development

The number of patients receiving relevant health services provided or sub-contracted by West Suffolk NHS Foundation Trust in 2018/19 who were recruited during 2018/19 to participate in National Institute for Health Research (NIHR) Portfolio or commercially adopted research studies approved by a research ethics committee exceeded 1,500 participants (an increase from 680 in 2017/18).

Seven-day services

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

- Standard 2: time to consultant review – compliance with the standard of all patients seeing a consultant within 14 hours of admission has increased to 79% with 90% seen within 17 hours. Work continues to improve this standard and developments in the delivery of front of house services, such as surgical ambulatory care, will support sustained delivery in the coming years
- We already achieve standards 5 (access to diagnostics) and 6 (access to consultant-directed interventions) and expect to maintain this compliance
- Standard 8: ongoing review – 95% of patients who require a once daily consultant directed review receive such a review. Our focus for the coming year is ensuring reviews continue at the weekend if they are required.

The Trust has robust systems in place to comply with the revised reporting framework for seven-day services. In order to provide full assurance the Trust will replicate the national audit methodology as used for the spring 2018 audit. This allows for accurate comparison with previous audit results. It is expected that the audit will run bi-annually with both the framework template and detailed analysis presented to the Board for assurance.

Consolidating vacancies and rota issues

Since August 2018, the Trust has seen the opening of the new cardiac centre and AAU, along with opening more capacity in ED and a trial surgical assessment unit. These expansions, together with the increased demand experienced by the Trust has led to more doctors being required. While the human resources department aim to fill gaps via new appointments, there can be a delay in this process. New ‘locally employed doctors’ (LEDs), have been employed specifically for the cardiac centre and to cover the additional capacity in AAU.

There are further plans for eight additional LEDs from August 2019, covering the emergency department, general surgery and general medicine. In total, 30 LEDs will be specifically employed to ensure that we can safely fill our rotas and staff the wards, and ensure safer working hours for all doctors.

Staff who speak up (including whistleblowers)

The Trust uses the integrated policy recommended by Sir Robert Francis to support staff to raise concerns about patient care and other healthcare related matters. This policy is available to all staff on the Intranet.

The Trust offers a range of services available within the organisation to support Trust staff with concerns about patient safety, bullying and harassment and/or inclusion issues. These services supplement and support the role of Freedom to Speak Up Guardian and the Trust strategy of 'freedom to speak up, freedom to improve'. They are collectively promoted within the organisation as 'Staff Supporters' and as part of our health and wellbeing offer. The policy also clearly outlines the external routes available to raise concerns, should this be more appropriate.

- **Freedom to Speak Up Guardian** - this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
- **Designated executives, specified non–executive director and other senior staff** - the Trust policy outlines specific individuals who have a role to support any member of staff who wishes to speak up
- **Trusted partners** - these are volunteer members of staff who provide confidential, independent advice and a listening ear for issues such as bullying and harassment, and equality and diversity. There are currently 19 trusted partners from a range of clinical and non-clinical, and senior and junior roles. The role has existed in the Trust for some years as a resource to support those who feel bullied or harassed. In 2018 the role was extended to include staff who have lived experience of one or more of the characteristics protected by the Equality Act 2010 and who are willing to support others who have similar experience or by sharing knowledge and information
- **Tea and empathy** - on-call emotional support for anyone having a really bad day is provided by volunteer members of staff (clinical and non-clinical). Any member of staff can access the service by calling the switchboard
- **Chaplaincy service** - regardless of whether staff are religious, the chaplaincy team provides a listening ear in times of difficulty or crisis, whether personal or work-related, a space to talk about life, the purpose or the meaning of things, and pastoral counselling. For staff who have a faith, the chaplaincy service can also provide support with: practicing a faith or spiritual tradition, making contact with representatives of other faith communities and prayer support
- **Trust executive open door** - executive directors are in Time Out restaurant from 8.00am to 9.00am every Wednesday and staff are invited to drop by to talk informally to members of the executive team. This arrangement has been in place for more than two years
- **Other support mechanisms** - as part of our approach to partnership working with staff-side organisations we actively promote trade unions as a source of support for staff for health and safety advice, education support and member support for disciplinary issues. A lesbian, gay, bisexual and transgender + (LGBT+) network was set up in the Trust in the autumn of 2018 comprising members of the LGBT+ community working in the organisation and allies. The support network organised a training session run by the Terrence Higgins Trust for all staff in February 2019 on tackling homophobia. Trans awareness training is also provided by the Kite Trust to help ensure staff and patients who are trans receive appropriate support.

In addition staff are encouraged to seek the support of their line manager, the human resources team and specialist departments (e.g. health, safety and risk office, postgraduate medical education team and governance support).

Staff can access support through the Trust and community intranets through a single staff supporters landing page that has links to all services. Services are also advertised in the weekly staff information publication Green Sheet, at Trust induction by the executive director of workforce and communications and the Freedom to Speak Up Guardian and through promotional campaigns in the Trust. Where possible, evidence of use and the types of issues raised by staff are captured for monitoring purposes.

Goals agreed with commissioners

A proportion of WSFT income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between WSFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN goals for 2018/19 included the following national and local CQUINs:

- **Staff health and wellbeing:** a) responses via the National Staff Survey on wellbeing provision and musculoskeletal issues or stress caused by work; b) healthy food and drinks for staff, visitors and patients; and c) staff flu vaccinations
- **Sepsis:** emergency department and inpatients – screening and treatment, plus antibiotic prescription review
- **Antimicrobial resistance and stewardship:** reduction in antibiotic consumption and increased selection of antibiotics from the access group, 'AWaRe' (Access, Watch and Reserve) category
- **ECDS and mental health needs in emergency department:** expanding the use of ECDS (emergency care data set) diagnosis options and monitoring selection of frequent attenders, including collaborative working with the mental health provider
- **Clinician pre-referral advice and guidance to GPs**: via e-referral service (eRS)
- **Preventing ill health:** inpatient tobacco and alcohol screening, advice, refer/treat.

For 2019/20 these goals will be developed to include:

- **Antimicrobial Resistance**: Lower UTI - Antibiotic prescriptions in older patients (65 & over) meeting guidance and four criteria; and Elective colorectal surgery - Antibiotic prophylaxis being a single dose and prescribed in accordance with guidelines
- **Preventing hospital falls occurring in older patients**: with three falls prevention actions
- **Adults managed in the same day setting** and discharged to usual place of residence who have confirmed: Pulmonary Embolus, Tachycardia with Atrial Fibrillation and Community Acquired Pneumonia.

The total CQUIN funding value for 2018/19 was £3,511,673 (compared with £3,428,060 for 2017/18).

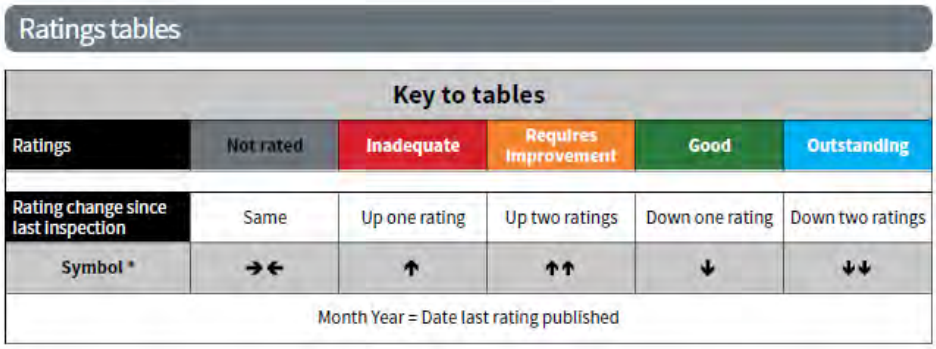
What others say about us

WSFT is required to register with the **Care Quality Commission (CQC)** and its current registration status is unconditional. The CQC has not taken enforcement action against WSFT during 2018/19. WSFT has not participated in special reviews or investigations by the CQC during the reporting period.

During 2018/19, the Trust was not the subject of any inspection of the core services.

Following an inspection in 2017/18 WSFT was **rated as 'outstanding'** overall with individual ratings of Safe ('good'), Effective ('outstanding'), Caring ('outstanding'), Responsive ('good') and Well-led ('outstanding').

Rating table key



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

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

West Suffolk Hospital

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

Community Health Services

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

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

West Suffolk NHS Foundation Trust

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

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

WSFT is one of only 23 trusts in England to be given the top rating.

In its report, the CQC praised staff, saying they place the patient at the centre of the care they provide and describing them as “open, helpful and dynamic” in both outpatients and end-of-life care. The positive feedback the Trust receives from patients and visitors was also commended, along with the safety of services and the infection control processes which are in place. They also mentioned senior leaders were visible and approachable. All the staff they spoke with said that the executive team were approachable with an open door policy. Staff felt well supported by the senior team who addressed concerns and enabled them to make positive changes to service delivery locally. Members of the senior team visited areas of the Trust regularly.

Examples of outstanding care highlighted by the CQC include:

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

Three areas were previously identfied as ‘requiring improvement’ - urgent and emergency care (safe), critical care (responsive) and maternity (well-led). The Trust has ensured ongoing executive led scrutiny of the issues contained within the 2016 report to ensure they have been addressed. Most recently the ‘mock CQC’ inspections found the following:

Urgent and emergency care (Safe)
The emergency department (ED) has made improvements in all areas, and has addressed some of the issues identified in previous inspections and also by the CQC’s last inspection. However some of these areas of concern remain. Depending on the model of care and flow through the department children may still be mixed with both adult and ambulance arrivals. There are still insecure areas in both the assessment and treatment areas of the ED.

Critical care (Responsive)
Improvements have been made against the 'requires improvement' rating for Responsive. Delayed discharges are much improved and the visibility and priority of these has been highlighted through the bed meeting agendas. Intensive care unit (ITU) discharges receive the highest of priorities for beds. This has reduced the opportunity for single sex accommodation breaches. The visibility of patients in side rooms has been addressed with ITU staff maintaining awareness and vigilance. The high standards of care and outcomes for our Critical Care patients have recently been recognised by a positive GIRFT (getting it right first time) report.

Maternity (Well-led)
There have been many developments and changes to improve the leadership and team structure. This has resulted in an effective team approach which was really visible and was discussed positively when speaking with staff.

Medicines and Healthcare Products Regulatory Agency (MHRA) inspection
We continue to work with East Suffolk and North Essex Foundation Trust (ESNEFT) and North East Essex and Suffolk Pathology Services (NEESPS) to address regulatory and accreditation concerns. The MHRA undertook a wide-ranging inspection of the blood transfusion service in February 2019. While the visit recognised that improvements have been made it identified that further work is required. We are working with ESNEFT at a more strategic level to review the options for the networked provision of pathology services.

Awards and accolades

It has been an **impressive year for the Trust**, with many accolades and achievements to be proud of.

- Finalist in the **Health Service Journal Awards 2018** 'Using Technology to Improve Efficiency' category, for our work in piloting new digital communications tool, Medic Bleep
- Finalist in the **Student Nursing Times Awards 2019** 'Student Placement of the Year: Hospital' category, in recognition of our nursing student support programme
- Rated by our staff as the **best general acute in the country** for giving them control and choice over how they do their work in the latest NHS staff survey (2018)
- Rated as the top hospital in England, Wales and Northern Ireland for meeting **best practice criteria for hip fracture treatment** by the National Hip Fracture Database
- Chief executive Dr Steven Dunn **awarded a CBE** for services to health and patient safety in the prestigious Queen's New Year Honours list
- Fifty women across the Trust announced as **'inspirational women of west Suffolk'** as part of NHS 70th birthday celebrations
- Scored **top in the East of England for doctors' overall training satisfaction** in acute trusts, in the General Medical Council's national training survey (2018)
- Named as one of the **CHKS Top Hospitals for 2018**, healthcare improvement specialists
- Hannah Sharland, estates and facilities project manager, was awarded the **individual development award** at the recent Health Estates and Facilities Management Association (HefmA) awards
- Our My WiSH Charity was chosen as the regional winner in The Patient and Public Involvement Award category of the **NHS70 Parliamentary Awards**.

These accolades go hand-in-hand with some of our ongoing developments and achievements across the past 12 months. As a snapshot:

- Delivery of a £5.2m **cardiac suite** that allows us to deliver procedures like angiography and pacemaker fitting on site for the first time
- Opening of a **new acute assessment unit** (AAU) that has transformed how we assess and treat our emergency patients

- Introducing **Medic Bleep**, a digital app to replace physical bleeps, that has been evidenced to save valuable staff time (average 48 minutes per shift for junior doctors and 21 minutes per shift for nurses) so they can spend more of it caring for patients
- **Linking our electronic patient care** record in the emergency department with Cambridge University Hospitals NHS Foundation Trust, so that clinicians at either site can access information on a patient's record held at the other Trust
- Helping the NHS West Suffolk Clinical Commissioning Group (CCG) area to achieve the **fewest excess bed days in the country** (the term used to describe where people are still in hospital when they no longer need to be there).

Data quality

WSFT submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patients' valid NHS number was:

Valid NHS number	WSFT	Midlands and East (East)	National
Admitted patient care	**99.7%**	99.6%	99.4%
Outpatient care	**99.9%**	99.9%	99.6%
Accident and emergency care	**98.6%**	98.4%	97.5%

(The above figures cover April 2018 to January 2019 inclusive – taken from NHS Digital)

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

Valid general medical practice code	WSFT	Midlands and East (East)	National
Admitted patient care	**99.9%**	99.9%	99.9%
Outpatient care	**99.9%**	99.8%	99.8%
Accident and emergency care	**99.9%**	99.6%	99.8%

(The above figures cover April 2018 to Jan 2019 inclusive – taken from NHS Digital)

WSFT's information governance assessment report overall score for 2018/19 was 40/40 assertions met. All 100 mandatory evidence items were provided. WSFT will be taking the following actions to improve data quality:

- Continue to conduct data quality audits on WSFT data to ensure its completeness and accuracy, and feedback audit results to the clinicians involved in the recording of that data
- Continue to increase awareness of the importance of accurate data recording throughout WSFT
- Working with our digital partner, Cerner, to improve reporting from e-Care (our electronic patient record).

WSFT was not subject to the payment by results (PbR) clinical coding external audit during the reporting period 2018/19. A local audit was undertaken and the error rates reported in the latest published audit for that period for diagnosis and treatments coding (clinical coding) were:

Data field - inpatients	Error rate
Primary diagnosis	2.2%
Secondary diagnosis	3.6%
Primary procedure	3.6%
Secondary procedure	7.3%

The audit sample was 225 finished consultant episodes (FCEs) from medical, surgical and woman and child health services. The results of this audit should not be extrapolated further than the actual sample audited.

3.5 Performance against 2018/19 priorities

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

Deliver personal care: deliver measurable improvements in the patient experience

- Patient, family and carer voice is represented throughout the organisation
- Patient and family involvement in assurance and improvement
- Improve shared decision making
- Implementation of choosing wisely UK recommendations

Patient, family and carer voice is represented throughout the organisation
Patient and family involvement in assurance and improvement

Following work to promote VOICE (our patient, public and family carer representative group) we received 10 new applications to join the group. The VOICE members themselves were actively engaged in the recruitment process. The group was involved in co-production of the Trust's Always Event®, which focused on aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system. The Always Event® is now focussing on improving awareness of when a patient is at end-of-life and supporting their families, upcoming projects include looking at signage for the new cardiac centre, supporting the patient experience team in looking at the possibility of toast on wards and juice cartons for patients that are easier to open, and reviewing the Trust's equality, diversity and inclusion objectives. Representatives from VOICE attend the learning from deaths group and patient portal user group.

Action taken during 2018/19

- Development of Trust experience of care strategy
- Engagement links between patient experience and the capital projects team to engage on projects; one example of this in 2018/19 was assessing disruption to patients during roof works
- Co-production with VOICE for learning from deaths review process, which featured as a case study in CQC guidance
- VOICE involvement with the development and implementation of the patient portal
- Patient engagement activity as part of interviews for the executive chief operating officer and the executive director of workforce and communications
- Always Event®: co-production team of staff and patients to implement a quality improvement project across the Trust, ensuring patients feel well-informed on admission to hospital.

Work planned for 2019/20

- Further integrating co-production throughout the organisation through the patient VOICE group, including Always Event® and elective care transformation programme
- Organisational roll-out of virtual interpreting (VI)
- Developing feedback collection in community settings
- Conduct regular area observations to assess the patient experience in our public spaces across the Trust
- Explore furthering the accessibility of information including our Trust website and information leaflets
- Improving feedback engagement with our children and young people, including exploring updates to the physical environment of the paediatric ward
- Furthering our support to family carers by identifying a safe space for them to recuperate and reflect whilst their loved one is in hospital.

Improve shared decision making

Shared decision making 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. The conversation brings together the clinician's expertise, such as treatment options, evidence, risks and benefits and what the patient knows best: their preferences, personal circumstances, goals, values and beliefs. NHS England describes how shared decision making forms part of the NHS Long Term Plan's commitment to make personalised care business as usual across the health and care system.

Examples of local development include a patient-led initiative where people living with lung conditions come together for a weekly session to maintain their fitness and support each other to improve their physical and mental health. This follows on from an initial six-week exercise and education programme run by the community pulmonary rehabilitation service. As well as the exercise and advice, the participants gain valuable peer support and stimulation as well as the positive benefits of getting out of their home into an environment where they can share something with other people.

Choosing Wisely

Choosing Wisely UK is hosted at the Academy of Medical Royal Colleges, the coordinating body for the UK and Ireland's 23 medical royal colleges and faculties. The Academy asked all royal colleges and faculties to identify five treatments or procedures commonly used in their field, which are of questionable value and therefore the appropriateness of their use should be discussed carefully with patients before being carried out. Each was rigorously researched and cross-examined by some of the most eminent doctors in their specialty and then cross-referenced with National Institute for Health and Care Excellence, which provides doctors with guidance on treatments. NICE, as it is generally known, has been involved in the process every step of the way.

The key aim of Choosing Wisely is to change the culture when it comes to prescribing. There are a set of recommendations from 2016 to 2018 for different specialties across the Trust to consider. These have been transferred into baseline assessment templates for the allocated specialties and leads to review. Progress on this line of work will be reported at the Trust's clinical safety and effectiveness committee (CSEC).

Deliver safe care: set goals and measure quality improvement for key indicators of harm

- Increase the compliance with risk assessment for venous thromboembolism (VTE), improve the coverage of risk-based VTE prophylaxis and reduce the incidence of hospital-acquired VTE
- Reduce the incidence and severity of pressure ulcers acquired in our care
- Reduce harm from falls
- Improve nutrition in inpatients and patients with long term conditions cared for in the community
- Improve fluid management in inpatients (acute and community)
- Reduce the incidence of acute kidney injury
- Timely treatment of patients with sepsis

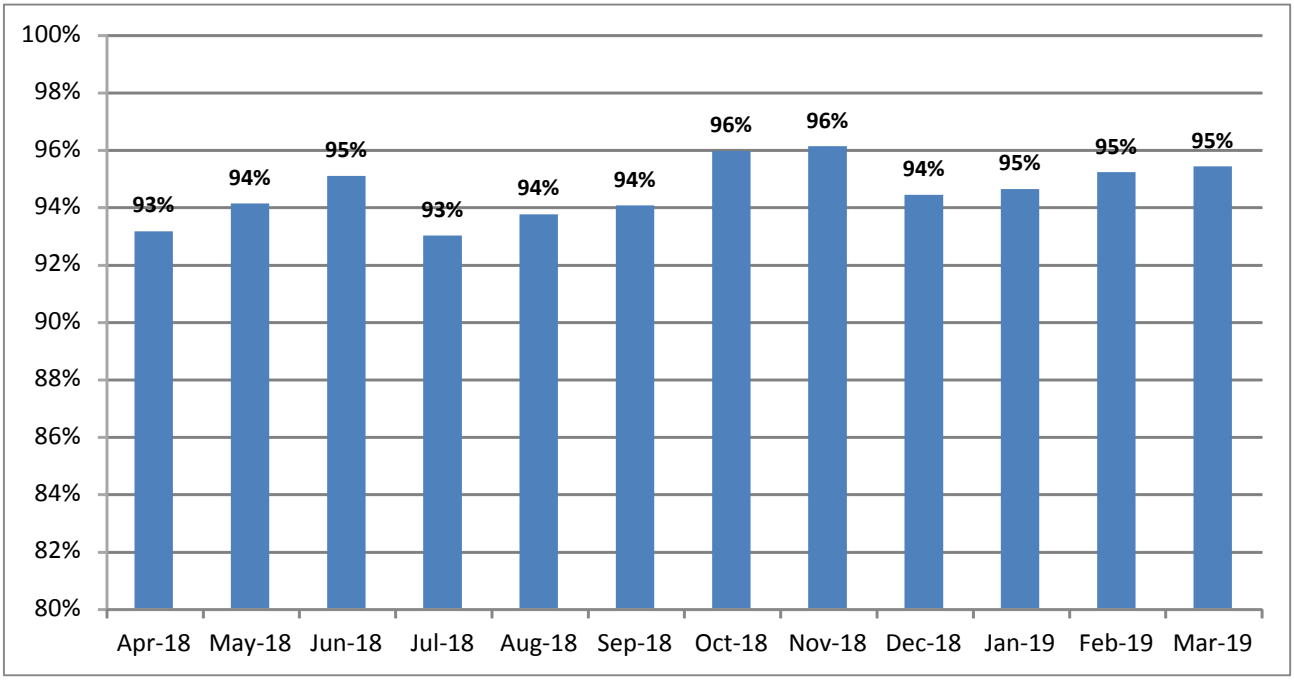
Venous thromboembolism (VTE)

We aim to:

(a) Increase compliance with risk assessment for VTE
(b) Improve coverage of risk-based VTE prophylaxis
(c) Reduce incidence of hospital-acquired VTE.

(a) **Risk assessment for VTE**

Percentage of VTE assessments completed



e-Care data capture enables the production of a performance report for compliance with VTE risk assessment. Trust-wide compliance has improved to 95% however this is not consistent across all departments and specialties. Using drill-down into the data has enabled the identification of ward areas for targeted interventions in 2019/20.

A quality improvement project to support this focus is in the early stages of development with support from the Thrombosis committee and deep vein thrombosis (DVT) nurse specialists. A 'table-top' exercise has been organised for early 2019/20 to add momentum.

(b) **VTE prophylaxis**

Focus on risk-based VTE prophylaxis is being driven by the implementation of NICE guidelines issued in 2018 (NG89). A baseline assessment of compliance has been completed to assess areas for improvement. WSFT is compliant with the core guidance on VTE assessment and prevention. A project to update protocols to reflect NG89 and then ensure these are fully embedded in practice will be a major project during 2019/20. The new guidance is very detailed and expands the indications for extended VTE prevention. In some areas such as ENT and haematology the clinical practice is already compliant and the protocols are being updated to ensure full compliance.

(c) **Reduction of hospital-acquired VTE**

Reported occurrence of hospital-acquired VTE resulting in serious harm are reviewed using the Trust incident reporting pathways and, in addition, any cases where a VTE is noted on a patient's death certificate are reviewed by the Trust's thrombosis clinical lead to confirm whether there is any need for a more detailed review.

The VTE information leaflet 'Preventing blood clots in hospital' will be rolled out to all inpatient areas to provide patients, families and carers with further knowledge in regard to the risks of VTE whilst in hospital and on discharge.

Additional actions planned for 2019/20

- Baseline assessment and implementation of any relevant recommendations from NCEPOD pulmonary embolism study (www.ncepod.org.uk/pe).

  This study (publication anticipated summer 2019) has the stated aim "*To identify and explore avoidable and remediable factors in the process of care for patients diagnosed with pulmonary embolism*."

- Review of the opportunities to use e-Care to produce audit data to replace the current manual quarterly junior doctor audit.

  This manual audit provides a snapshot of indicators related to VTE assessment on admission and re-assessment within 24 hours, weight recorded, thrombo-prophylaxis (low molecular weight heparin) accurately prescribed and administered and renal function noted. Moving this audit to an e-Care report provides the benefits of more frequent, increased data (all patients monthly, not just a snapshot) and enables the junior doctor cohort to undertake audit in other subjects where e-Care data is not yet available.

Pressure ulcers

WSFT aims to improve on our achievements to date of reducing harm to patients whilst they are under our care through the reduction of pressure ulcers on our inpatient wards and in those patients under the care of our community teams.

Nationally there have been changes in reporting, classification and investigation of pressure ulcers introduced by NHS Improvement (NHSI) during 2018 with implementation by 2019. Locally updated guidelines are now in place and new classifications reflected in our Datix (incident) reporting systems. This is currently being disseminated into practice and we are developing our training processes and reporting systems to reflect the new requirements.

Recommendations include changes to grading and terminology; the timeframes for reporting and ending the use of 'avoidable' and 'unavoidable' terminology. This has also given us an opportunity to integrate our pressure ulcer policy across the community and acute settings.

With the removal nationally of the definition of avoidability, the opportunity to measure progress has been altered to focus on a more thematic approach, looking at areas of potential risk in the pathway of pressure ulcer development such as proactive risk assessment, regular skin inspection, nutrition and hydration, equipment provision, informed patient concordance and mental capacity. New methods of data capture for audit purposes will support this in 2019/20.

Developing new integrated ways of working in 2019/20
In line with our new integrated services across the Trust, the tissue viability department has been developing ways to work across community and acute services. The hospital tissue viability service has been working closely with the head of nursing for community and integrated services to develop a new model of integration that can support pressure ulcer prevention and complex wound care across the acute and community settings. There is also potential to integrate a CCG-funded care home tissue viability nurse, who will support patients and staff within nursing homes across the west of Suffolk. Integration will involve training, support and participation in action groups to scrutinize and identify trends in pressure ulcers in both community and acute settings.

Moisture damage prevention and new pathways
Changes to pressure ulcer reporting in the new NHS Improvement guidelines stipulate that moisture lesions/incontinence-associated dermatitis is now reported. This is an opportunity to capture data regarding the incidence of moisture damage and can be used to target training, support and development in clinical areas as we are aware there are strong links between incontinence-associated dermatitis and the development of pressure ulcers.

Keeping the skin viable is a key component in the prevention of pressure damage. In response to new guidelines and our increased focus on monitoring and preventing the occurrence of pressure ulcers, the tissue viability team has developed our pathway for the management of moisture lesions and introduced a new product to complete a three tier management pathway. The third line has been introduced as a solution to significant moisture damage and has been trialled with excellent results. There is now additional ward based training and targeted training through our link nurses to ensure this product is used appropriately - supporting skin care and providing another tool in the prevention of pressure ulcers.

Ongoing actions in 2019/20

- Participation in the NHS Improvement pressure ulcer collaborative. This national collaborative supported quality improvement measures to ultimately prevent and reduce incidence of pressure ulcers
- Purchased a repositioning Monitor, Alert, Protect (MAP™) system as a teaching tool, trialled on our respiratory ward. The goal is to roll this training out to all wards and departments
- Repositioning roadshows - our experience with using the MAP as a teaching aid has given staff across all disciplines the opportunity to engage and put themselves in the patient's position as they see a visual representation of their pressure areas
- Residential homes are being targeted to promote pressure area care in these settings. There are plans to take the MAP system into a local residential home and work alongside a district nursing team to provide education and promote excellence in pressure area care in care home settings.

Ongoing training provision

- Continuing with pre-registration student nurse placements and raising the profile of student nursing within the pre-registration curriculum. This engagement with students at early stages within their training is an excellent opportunity to support tissue viability and pressure area care management and instils the basic fundamental principles of patient care in relation to skin care and pressure areas
- In addition to the pre-registration program we are working with the practice development team to support the development of band 3 and 4 staff to develop wound care and pressure area care training and development
- The tissue viability team continues its commitment to training and development across the hospital. Bitesize training sessions are ongoing and it is felt that this education is essential in the reduction of pressure ulcer incidence and promoting quality in wound care in general.

Falls

In 2018/19 the Trust participated in the NHSI Falls Collaborative Project. Initial focus of the collaborative was on prevention of frequent fallers. The team felt there was a cohort of patients who were at high risk of falling due to previous falls and were not highlighted to receive specialist care. A series of engagement activities were undertaken with an initial focus to review the use of the leaf symbol currently used to alert staff (as well as patient, visitors and carers) to patients who are at falls risk or have fallen. The leaf is used in different colours for patients at risk of falling and having already fallen.

Feedback on this exercise suggested a new sign of a falling person. Patients and relatives were asked their opinion as it was recognised that this is less confidential than the generic leaf design and were supportive of a change if it would help prevent falls.

Review of the incident reporting dataset is planned for 2019/20 to enable ongoing audit of patients who have fallen twice or more to highlight learning themes. WSFT undertakes a structured root cause analysis (RCA) for all falls resulting in serious harm. In 2018/19 the themes arising from these RCAs included: patient frailty contributing to severity of outcome from the fall; patient confusion due to clinical condition; completion of care plans and safety assessments; completion of lying/standing blood pressure (LSBP); end-of-life/last day rounding; medicines review on admission; and postural hypotension. Actions agreed to address these issues include:

- Consideration of alternative wander guards which are attached to the bedframes and utilised until full risk assessments can be carried out. Wander guards provide a warning system to create an alert if a patient is independently mobilising unsupervised which might put them at risk. Current devices have the potential to be removed by a patient (e.g. with dementia) so new options are being considered, including for example a mat on the bed which can register movement and send a message to the nurse in charge and/or trigger an alarm so that the staff can attend
- Last day rounding to be included in the Trust wide nursing documentation review.
- Medical director and chief nurse to cascade to clinical directors, heads of nursing, matrons and ward managers the importance of acting upon postural hypotension
- Introduction of link practitioner study days three times a year
- Ensure all wards have falls link nurses (ward champions) to attend study sessions and feedback to staff
- Use of Perfect Ward App data to review completion of assessments and falls prevention care plan.

Other actions taken within the year include:

- Bay-based nursing model being implemented across the Trust. Bay-based nursing alters staffing ratios and arranges nurses according to the layout of wards. Non-registered nurses are assigned to a single bay, and are responsible for the patients within that bay for the entirety of their shift. If they have to leave their bay for any reason, a registered nurse will cover that bay for the time that the assigned nurse is away
- Relaunch of falls focus group with an emphasis on ward-based champions and the sharing of best practice to reduce falls. First falls champion study day well was attended with two more days planned later in the year
- All wards have identified a falls champion
- Sourcing improved gripper socks with grippers over whole sock rather than sole only, and looking into introducing red gripper socks for patients at high risk of falls
- NHSI collaborative work in relation to in-depth multidisciplinary discussions at ‘huddle’ to be audited in 2019
- Focus work around frequent fallers following successful completion of work within the NHSI collaborative. Focus on two clinical areas, one acute and one community. Planned roll-out in 2019 of frequent faller symbol within clinical areas
- Falls training to be reviewed in light of NHSI collaborative work
- Ongoing discussions around development of a falls prevention lead role within current senior workforce.

Nutrition

Following the completion of the NHSI nutrition collaborative, work continues to improve nutritional assessments, referrals and care planning. We are also reviewing and enhancing the implementation of protected mealtimes to ensure that patients have a dedicated mealtime, free from as many interruptions as possible. Work has also been undertaken to review the multiple data and measurement sets that existed for food, fluid and nutrition and these have been streamlined so they will form part of the patient safety report. The communication team is working to improve this process and the nutrition team are aiming to have a process of three measures to feedback to teams:

- Information on compliance from patient safety dashboard monthly
- A quarterly audit to review accuracy and monthly assurance via 'Perfect Ward app'
- Quarterly protected mealtime audit.

Compliance with completing the malnutrition risk assessment is reported monthly in the integrated quality and performance report (IQPR) to the Board. This reports the percentage of patients who have a malnutrition risk assessment performed within 24 hours of admission. The current data indicates that the majority of wards are achieving between 80 and 90% compliance. However, there are some areas which are significantly falling short of the expected target leading to a decrease in the overall figure. On analysis, the areas which are not achieving the assessment within 24 hours of admission are the wards which accept direct admissions from the emergency department, mainly the stroke, respiratory and surgical wards.

To improve compliance work is ongoing with the nutrition group and information team to create a dashboard for ward managers and senior matrons to be able to review the data specific to their area and raise awareness of poor compliance. The aim of the dashboard is to present data that promotes meaningful actions from the individual departments/wards and, where areas are struggling to achieve compliance, enable targeted intervention by the senior matron team. Once finalised this dashboard will also provide data to allow monitoring of improvement pathways.

Nutrition patient safety dashboard	2018/19
% of patients with measured weight	79.5%
% of patients with a MUST/PYMS assessment completed for the encounter	87.6%
% of patients with a MUST >= 2 assessment that have a food chart	66.7%
% of patients with a MUST/PYMS score > 0 that have a nutrition care plan	44.0%
% of Patients with MUST >= 2 or PYMS >= 1 that have a referral to dietitian	74.4%
% of Patients with MUST >= 2 or PYMS >= 1 that have a dietitian contact within two working days from dietitian referral	80.8%

MUST - Malnutrition Universal Screening Tool
PYMS - Paediatric Yorkhill Malnutrition Score

Individual wards have been engaging with additional training from the dietetic team including activity to raise awareness during Nutrition and Hydration week in March. Nutritional care is also monitored via the Perfect Ward app. The majority of this work is ongoing and requires frequent review and revisiting. A key area of learning surrounds the data we are collecting and how we present and improve on this. There is also specific work starting with a focus on stroke patients following the publication of the 2018 Sentinel Stroke National Audit Programme (SSNAP).

Acute kidney injury (AKI) and fluid balance

Planned improvements have focused on improved monitoring of patients with AKI as part of e-Care to enable prompt treatment. The development of the AKI alert on e-Care now informs the clinical team of a patient with an identified AKI stage 2 and 3, with the ability to assist the clinician to navigate to the appropriate care plan (AKI7) and commence treatment in a timely manner. These alerts and care plans were launched during the deteriorating patient awareness week (September 2018). This alert guides the clinician to the appropriate care plan within the order set. This includes consideration of regular monitoring, medication, fluid management, investigation and specialist review. In addition, nursing staff receive an alert for those patients triggering with AKI stage 2 and 3, outlining a series of required actions.

Reflecting the complex nature of nephrology-related issues (inclusive of AKI, fluid balance and hyperkalemia) a task and finish group has been set up led by a consultant nephrologist and comprising doctors, senior nursing staff and clinical nurse specialists. This group meets regularly to review of AKI and other renal-related issues, ensure compliance with best practice guidance and patient care, and review current guidance and local policies and processes.

Upcoming work planned for 2019/20

- AKI clinical guideline is currently being updated in order to follow national guidance and e-Care pathways
- Doctor-led clinical audits of:
  - AKI care plan use following stage 2 alert
  - qualitative questionnaire of junior doctors' compliance with care plans and procedures
  - management of AKI in ITU
  - information given to GPs regarding patients' requirements following discharge
- The AKI task and finish group exploring six months of AKI stage 1 (retrospective data) to identify thematic issues
- Develop a management pathway for patients with mild AKI who could be managed in ambulatory care
- AKI treatment (including the e-Care alert and care planning) is now included within the following education: medical induction; management of the deteriorating patient study day; and junior doctor teaching sessions
- New sepsis/AKI project nurse will initially focus on sepsis data, but AKI will also be part of their remit, with particular focus on collecting staging data and exploring themes in the quality of treatment. This role will be able to link with the outreach and education teams to enhance training.

Sepsis

The planned improvements focus on improved alerting of patients with sepsis or severe sepsis through e-Care to enable prompt treatment. Any patients who meet the St John sepsis alert scoring system in two or more parameters are now flagged as either a sepsis or severe sepsis alert to nursing and medical staff to implement care planning and treatment. These triggers include vital observations and blood results and the severity of the alert is aligned to the vital or blood results. Management of sepsis after admission to hospital involves three treatments and three tests, known as the 'sepsis 6':

- Give high-flow oxygen
- Take blood cultures
- Give intravenous (IV) antibiotics
- Start IV fluid resuscitation
- Check haemoglobin and lactates
- Monitor urine output.

The timely recognition and treatment of sepsis was reviewed during the deteriorating patient awareness week (September 2018) and on the sepsis day held by the Trust, where members of the outreach team and the acute oncology service (AOS) spent the day floor-walking and raising awareness of the signs and management of sepsis.

Action taken during 2018/19 and planned 2019/20

- Improve compliance with the confirmation of sepsis proforma used by medical staff and the instigation of care planning to guide treatment
- Task and finish group to further develop management of sepsis. This group is led by the deputy chief nurse and head of patient safety and reports to the deteriorating patient group
- Sepsis/AKI project nurse will be able to complete the CQUIN audits in a timely manner and act accordingly on the results by focussing on areas that require improvement. The project nurse will work with the patient safety and deteriorating patient teams to understand themes and issues regarding patient care relating to sepsis
- The sepsis tool that is used within e-Care is being reviewed to assess whether it needs modifying and this will be determined by the sepsis group
- Proposed quality improvement project to increase the taking of blood cultures in patients with suspected sepsis
- Sepsis/AKI project nurse working with the antimicrobial pharmacist and audit nurse to review the treatment at 72 hours as per CQUIN guidance.

Deliver joined-up care: explore and develop more effective models of care, engaging with our partners and community

- Getting it right first time (GIRFT)
- Deliver innovative, integrated and sustainable models of care within our community (Buurtzorg Test and Learn)
- Improve usefulness and timeliness of discharge summaries

Getting It Right First Time (GIRFT)

This national programme looks at unwarranted variation in activity and outcomes in NHS trusts. GIRFT is a clinically-led programme implementing recommendations locally and nationally across 35 clinical specialties to reduce unwarranted variation, improve the quality of patient outcomes and deliver operational productivity improvements that translate into resource savings. Regional GIRFT hubs have been created to support trusts with implementation. The GIRFT process involves a six-stage implementation pathway:

- Phase 1 – preparation and gathering evidence. Specialty reviews are led by clinicians who are experts in their field and understand the disciplines and services they are reviewing
- Phase 2 – bespoke data pack distribution to help clinicians, managers and other members of the hospital team understand what the variations are, what needs to be done to address them and explore the challenges they face
- Phase 3 – GIRFT clinical lead undertakes a number of 'deep dive' visits to present the trust data pack and discuss it with the hospital team with an aim to incorporate recommendations into trust implementation plans
- Phase 4 – national report publication following completion of all the individual trust reviews to provide detailed evidence of the benefits that proposed improvements can bring
- Phase 5 – data refresh and re-issue to help re-prioritise implementation efforts
- Phase 6 – transition to business as usual.

The WSFT has had an ongoing schedule of deep dive visits with opportunities highlighted according to the themes of: better data quality, improved patient outcomes, increased patient throughput and increased operating capacity. For each deep dive the attendance from the Trust includes the executive team, medical staff, nurses, managers, allied health professionals (AHPs) and coding colleagues.

Following reviews action planning meetings are held and in 2019/20 implementation plans for the following opportunities were agreed:

- ENT: opportunity to increase tonsillectomy procedures being carried out as a day case for adults and paediatrics
- Obstetrics and gynaecology: developing a neonatal transitional care setting
- Ophthalmology: the implementation of an electronic patient records (Open Eyes) is being supported by the GIRFT model in terms of long-term sustainability moving into business as usual.

In 2018/19, the Trust had four GIRFT deep dive visits with a further three scheduled to take place over the next five months which will follow the standard pathways.

Date of visit	Specialty
17/09/2018	Emergency medicine
08/01/2019	General surgery
07/02/2019	Intensive and critical care
05/03/2019	Dermatology
Planned for 2019/20	
June 2019	Endocrinology
June 2019	Radiology
September 2019	Stroke

Buurtzorg Test and Learn

In an example of working as an integrated system, the West Suffolk Alliance continues to develop a system which coordinates health and social care services around the patient, using the Dutch 'Buurtzorg' model. The Buurtzorg model focusses on holistic, person-centred care, with a highly qualified workforce.

In October 2017 the neighbourhood nursing and care team (NNCT) was established and in February 2018 the team started accepting patients. The team in Barrow are co-located in the GP practice which has enabled a new level of communication and coordination between the service offered by the GPs and the NNCT. In 2018/19 the developing model in the west of Suffolk has been the subject of a King's fund evaluation and the recommendations from that report will provide the basis for an action plan and next steps in 2019/20 and beyond.

Improve usefulness and timeliness of discharge summaries

We have a responsibility to provide high quality and timely information to other health professionals that will provide onward care to patients who have been discharged from hospital. For inpatients we do this through providing a discharge summary to the patient's GP. The commissioners have set targets for how quickly we need to send discharge summaries to primary care and this workstream was selected to support us in achieving this. In addition, we extended the scope to include the quality of the information provided as we believe this is equally as important as speed.

Action taken during 2018/19

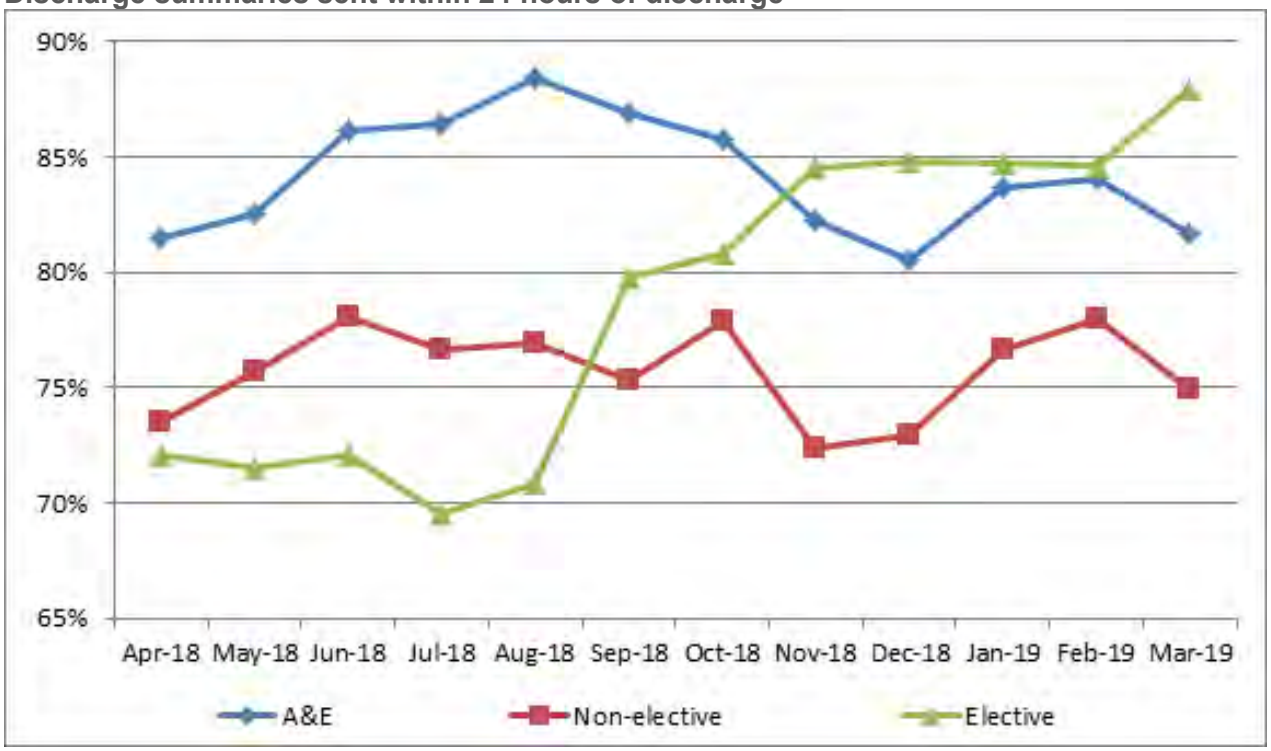
- We established a dedicated coaching role to support junior doctors in improving quality of discharge summary information
- We worked closely with the CCG to ensure that this issue was tackled in partnership with primary care. We are being advised by a GP who will also be delivering teaching sessions to junior doctors. In addition we have established a joint CCG and WSFT primary care helpdesk that handles all queries around discharge summaries
- We have introduced weekly performance reporting through to managers with the chief operating officer taking oversight of supporting those areas that need extra help. Areas are required to produce remedial action plans where underperformance is identified
- We have introduced new workflows for high throughput areas.

Current status

For planned inpatient episodes we have seen significant improvement in the number of discharge summaries that are sent within the CCG deadline of 85% of summaries being sent within 24 hours – with sustained performance just below this target.

We have made little sustained improvements within non-elective or ED, which both remain below the CCG target of 95%. A&E performance has remained relatively static across the year and this continues to be our most difficult area to achieve compliance.

Discharge summaries sent within 24 hours of discharge



Action to be implemented in 2019/20

- Continue to work in close partnership with the CCG to support clinicians in complying with targets
- Review discharge summary process within e-Care to see how it can be made more user-friendly for clinicians
- Continue weekly performance monitoring
- Dedicated work with ED to support them in improving performance.

Support a healthy start: promote a healthy pregnancy and ensure every child has the best start in life
• Involvement and engagement with the maternity and neonatal safety initiative

Maternity and neonatal safety initiative

Two main projects ongoing as part of the regional collaborative working with the Eastern Academic Health Science Network (EAHSN) are:

- PReCePT - offering magnesium sulphate to prevent cerebral palsy in pre-term
- Developing a neonatal transitional care setting.

(a) PReCePT - offering magnesium sulphate ($MgSO_4$) to prevent cerebral palsy in pre-term

Nationally only 43% of women are offered $MgSO_4$ to prevent cerebral palsy in pre-term (less than 30 weeks). We aim to increase the number of eligible women offered $MgSO_4$ to 85% by December 2019.

Actions agreed and ongoing:

- Lead consultant and paediatrician, two midwife champions allocated
- Local policies and patient information updated
- Care pathway developed

- Improved knowledge base – posters in place and staff survey ongoing
- Midwives, obstetrician and paediatricians - training programme in progress
- Monthly monitoring of progress by the women's health governance group
- Network presentation to staff on project and support from the clinical network
- Few babies at WSH give birth <30 weeks, therefore initial data-set is very small.

(b) Developing a neonatal transitional care setting

Currently the service does not have a designated area for babies requiring transitional care on the postnatal ward with their mothers. This project will develop a transitional care setting where babies with specified clinical conditions can be nursed next to their mothers, preventing their separation. A dedicated transitional care bay will be created where babies with specified clinical conditions can be nursed next to their mothers preventing their separation. Mothers are cared for by midwives, babies are cared for by neonatal nurses.

Actions agreed and ongoing:

- Involvement of neonatal clinical network lead
- All admissions to the neonatal unit (NNU) are reviewed each month as part of the atain programme (avoiding term admissions to the NNU)
- Appropriateness of admission and if they could have received transitional care. In addition, consideration from an obstetric and midwifery perspective of whether the admission could have been prevented
- Monthly meeting with clinical risk manager or clinical risk midwife, NNU manager and consultant paediatrician, (consultant obstetrician available to review obstetric care but not at meeting)
- Any learning highlighted and fedback to staff via, 'Risky Business' monthly newsletter.

Atain is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term. The programme focuses on four key clinical areas which make up the majority of admissions to neonatal units. However, it is expected that shared learning from local reviews will identify other reasons for admission:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia – ischaemia).

Local reviews
For all unplanned admissions to the NNU for medical care at term, a thorough joint clinical review by maternity and neonatal services takes place each month to identify learning points to improve care provision, and considers the impact that transitional care service has on reducing admissions and identifies avoidable harm. Learning is identified and included on a rolling action plan. The review group includes:

- Neonatal ward manager/neonatal practice development nurse
- Clinical risk manager/clinical risk midwife
- Consultant paediatrician
- Consultant obstetrician (reviews records outside of the atain meeting).

Support a healthy start: promote a healthy pregnancy and ensure every child has the best start in life
• Increase advice and referrals to services to help address unhealthy behaviours

Increase advice and referrals to services to help address unhealthy behaviours

(a) Tobacco and alcohol

The Trust is midway through the final quarter of this two-year CQUIN. It has not met the challenging CQUIN targets. At the beginning of the CQUIN period, plans were put in place for training activities and changes to e-Care to ensure progress in meeting the CQUIN was achieved. This progress has not been demonstrated to date, due in part to problems with data collection. A new project was initiated at the end of 2018 to examine the reasons for this and to improve practice in this area.

So far, a range of information-gathering activities has been undertaken, and several 'plan-do-study-act' (PDSA) cycles have been initiated. Information-gathering has revealed that although levels of screening for tobacco and alcohol use are reasonably high in practice, they are not being captured by the CQUIN measures. There is a significant lack of engagement with the key item used to capture data for the CQUIN: the lifestyle screening form on e-Care.

An initial PDSA cycle was conducted with individuals on various wards, aimed to increase awareness of the CQUIN activities and improve knowledge. It also aimed to gather information on barriers to undertaking alcohol and tobacco screening, intervention and referral. The cycle concluded that levels of awareness and motivation were extremely low. Staff lacked confidence to ask about tobacco and alcohol use, particularly in relation to technical points such as calculating units of alcohol. Staff lacked awareness about referral routes. Although awareness-raising was successful in this initial cycle, it did not overcome barriers relating to completing the lifestyle screening form. The key barriers were that staff were either not aware of the form, or were not motivated to fill it in as it would entail a duplication of recording that they were already performing elsewhere.

The study element of this cycle led to the conclusion that the project should shift focus away from completion of the form and towards simpler awareness-raising messages and training. The next cycle involves trialling communications methods on a specified ward and recruiting a small number of staff for making every contact count or brief intervention training. The information gathered from this cycle will be used to inform a wider communications campaign, to include a hospital-wide awareness day. Awareness-raising is being supported by OneLife Suffolk and the WSFT communications team. Separate PDSA cycles will focus on training and the best way to improve knowledge among clinicians.

(b) Matneo: improve smoking cessation in pregnancy

The aim of this project is to improve the smoking cessation rate from 20% (2016) to 50% at delivery by 2020 at WSH. In 2016 the smoking cessation rate in mothers booked at WSH was 20% (national average 19.85%). Smoking is a risk factor for stillbirth and it was identified that 50% of mothers who had a stillbirth during 2014-2016 at WSH were smokers.

Actions agreed and ongoing

- Follow fully the recommendations of Saving Babies Lives (element 1) - audit to assess compliance has been completed, the results informing improvement plans for 2019
- Data is collected on a dashboard with monthly monitoring at the women's health governance meeting to measure the impact of action to improve the uptake of smoking cessation services

- Dedicated antenatal clinic each week for women who smoke (OneLife Suffolk providers of smoking cessation attend this clinic)
- Recognition of ongoing challenge of lack of feedback from OneLife Suffolk of women referred for smoking cessation.

Support a healthy start: promote a healthy pregnancy and ensure every child has the best start in life
• Increase advice and referrals to services to help address unhealthy behaviours

Mental capacity

The Trust's Safeguarding Adults at Risk of Abuse & Neglect policy sets out the process for the management of safeguarding concerns and processes, assessing mental capacity and applying for deprivation of liberty safeguarding (DoLS). The Trust's mandatory training for adult safeguarding includes the Mental Capacity Act (MCA) 2005.

In 2018/19 there was focused work to increase visibility of the adult safeguarding nurse on wards by offering teaching, support and advice. Safeguarding champion bi-monthly meetings also promote best practice, share experiences and promote the NHS safeguarding app. In addition, ward managers and senior matrons receive a monthly report on the number of applications submitted per ward.

It is recognised there are still improvements to be made and support continues to be focused on specific ward areas that have higher numbers of patients who lack capacity, to ensure teams are achieving accurate mental capacity assessments and applying for DoLS, as appropriate, and legally required.

A quality improvement project began in 2018 looking at compliance to submit DoLS and improve the quality of referrals. A baseline audit was undertaken with ongoing spot audits monitoring. The main areas for improvement from the audit are:

- Systematic recording of MCA and DoLS
- Ensure consistent quality of DoLs applications.

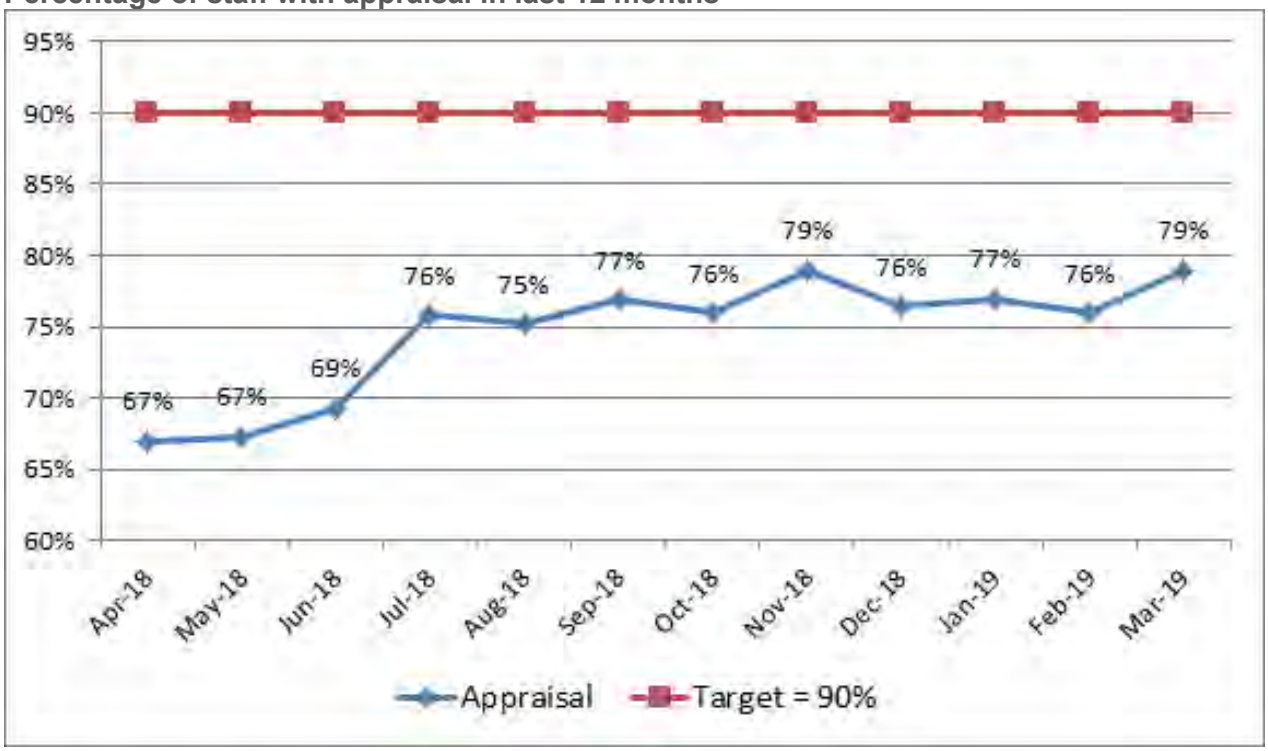
Further work for 2019/20
The Mental Capacity (Amendment) Bill 2017-19 is due to receive Royal ascent in April 2019. The legislation will have an impact on acute and community healthcare services but the level of impact is not yet known. It is envisaged an implementation programme will commence towards the middle of 2019. During this interim period community hospitals are required to continue to consider DoLs for all patients who lack mental capacity in community hospitals.

Support all our staff: support staff to flourish and learn whilst delivering high quality services
• Improvements in the number and quality of staff appraisals

Staff appraisals

The Trust policy states that 90% of staff must have had an appraisal in the last 12 months. The percentage is calculated by dividing the number that is shown as having an appraisal in the 12 month period, against the headcount of staff. This calculation is used in the national dashboards set up in the electronic staff record. 90% rather than 100% makes allowance for any staff that for example may be new starters or be on long-term sick leave.

Percentage of staff with appraisal in last 12 months



Completed appraisals are reported by email by the manager to the workforce team. This enables monthly reporting but relies on individuals completing the notification pathway. In 2018/19 human resource support was made available to improve compliance, including drop-in sessions as well as a presentation at the Core Brief monthly management briefing sessions.

In 2019/20 it is planned to roll out the manager self - service functions of the electronic staff record (ESR), first in the community and then rolled out Trust wide. There are a number of compelling reasons for this:

- The need to streamline the process for capturing timely appraisal information
- The introduction in 2019 of Agenda for Change incremental progression processes linked to appraisal
- Providing line managers access to up-to-date, clear information on appraisal.

The 2018 National Staff Survey was published in February 2019. The survey includes an element directly related to the quality of appraisals. This shows the Trust as being slightly better than the

national average, albeit with a large margin from best. The trend overtime shows improvement against both compared to the national average and against our own performance.

	2015	2016	2017	2018
Best organisation	6.1	6.3	6.4	6.5
Our organisation	5.1	5.0	5.2	5.5
National average	5.1	5.3	5.3	5.4

The National NHS Staff Survey provides a very useful source of data on a number of issues. Together with other data, this enables us to identify key workforce and service issues and develop further strategies for dealing with areas for improvement. In 2019/20 divisions will be asked to review their data with an aim to contribute a maximum of three new measures for each of the priorities for improvement. The improvements will be monitored at the divisional performance meetings. It is anticipated that this is likely to include quality of appraisal in at least some of the divisions (where performance is lower) and this is being driven operationally by the chief operating officer.

3.6 Other quality indicators

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on a monthly basis. These include priorities identified by patients and staff, issues arising from national guidance and research, and other stakeholders such as West Suffolk CCG. 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 targets

	2018/19 Target	2018/19 Actual	2017/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual
C. *difficile* - hospital-attributable trajectory cases [1]	15	**12 (2)**	19 (7)	23 (5)	22 (10)	23 (21)
18-week maximum wait from point of referral to treatment (patients on an incomplete pathway) [2]	92%	**88.8%**	86.42%	92.55%	96.25%	96.97%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge [3]	95%	**90.7%**	89.33%	86.89%	94.26%	93.54%
62-day urgent GP referral-to-treatment wait for first treatment - all cancers	85%	**84.6%**	86.68%	85.92%	88.05%	88.01%
62-day wait for first treatment from NHS cancer screening service referral	90%	**92.4%**	94.90%	97.85%	95.68%	95.10%
31-day wait for second or subsequent treatment - surgery	94%	**99.5%**	100%	100%	100%	100%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	98%	**99.8%**	100%	100%	99.87%	100%
31-day diagnosis-to-treatment wait for first treatment - all cancers	96%	**99.8%**	99.94%	99.92%	100%	100%
Two-week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	**90.7%**	94.62%	94.78%	98.46%	98.52%
Two-week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	**82.2%**	96.66%	88.54%	98.28%	97.19%
Maximum six-week wait for diagnostic procedures	99%	**97.3%**	99.92%	96.40%	91.68%	98.94%

[1] Figures in brackets exclude cases that West Suffolk CCG deemed to be non-trajectory (no identified lapses in care). One case for 2018/19 is pending CCG final opinion

[2] 2016/17 and April 2017 data is based on estimated performance

[3] 2016/17 data covers a 50-week period as excludes two weeks in May 2016 when e-Care was implemented.

As can be seen from the targets and indicators performance, we have delivered good performance and met a number of national targets. Performance has been challenging in a number of areas:

- **Maximum waiting time of four hours in ED** from arrival to admission, transfer or discharge
- **18-week maximum wait** from point of referral to treatment (patients on an incomplete pathway)
- **Cancer performance** for four standards.

We are working to ensure improvements are put in place to support service delivery for our patients in all of these areas.

Stroke services

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

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

Contractual stroke targets

	Target	2018/19	2017/18	2016/17
% of patients scanned within one hour of clock start	77%	**78.3%**	78.01%	74.62%
% of patients scanned within 12 hours of clock start	96%	**97.3%**	96.07%	97.00%
% of patients admitted directly to stroke unit within 4 hours of clock start	75%	**75.5%**	75.62%	74.01%
>80% treated on a stroke unit >90% of their stay	90%	**89.4%**	92.32%	88.47%
% of patients treated by a stroke-skilled early supported discharge team	48%	**56.5%**	48.32%	46.14%
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start	80%	**90.9%**	88.78%	84.87%
% of applicable patients who are assessed by a nurse and at least one therapist within 24 hours, all relevant therapists within 72 hours and have rehabilitation goals agreed within five days of clock start	75%	**85.8%**	85.33%	78.36%
% of eligible service users given thrombolysis	100%	**100%**	100%	83.52%
All stroke survivors to have a six month follow-up assessment	59%	**59%**	59%	57.59%

Incident reporting and learning

WSFT has continued to build upon and further strengthen the arrangements for managing serious incidents requiring investigation (SIRIs). The Board takes the lead on this process and all SIRIs have an executive sign-off. The Board receives a monthly summary of all newly-reported SIRIs and, on a quarterly basis an update on the outcome of each case as well as more thematic learning and actions arising.

The total number of SIRIs reported during 2018/19 was 42 (46* in 2017/18). These were reported in the following categories:

	2018/19	2017/18
Slips/trips/falls	9	7
Maternity/obstetric/neonatal incident	7	7
Confidential information leak/information governance breach	6	3
Diagnostic incident including delay	3	3
Healthcare associated infection	3	7
Medication	3	2
Treatment delay	3	8
Surgical/invasive procedure	2	1
Sub-optimal care of the deteriorating patient	2	8
Other	4	0
	42	46

* *In 2017/18 the Trust reported pressure ulcers through the serious incidents framework. However in 2018/19 the framework was updated to reflect national guidance and following clarification from the CCG, excluded all but the most severe pressure ulcers. In order to provide a suitable comparison between years the total for 2017/18 has been given excluding non-reportable pressure ulcers under the new guidance.*

By reviewing the SIRI cases and their respective investigations, key learning can be identified and actions put into place. Examples from 2018/19 include:

- Ward safety assessments to be completed on a regular basis even if the patient is mobile and independent
- Wash hand basins at the entrances to ward areas reduce the risk of cross-contamination when a ward/bay is closed due to, for example, norovirus and emphasised the importance of not moving staff from infected areas
- Early senior review and involvement should be sought if patient is not responding to treatment or is deteriorating
- Ensure all staff are aware of the correct method of requesting assistance and the importance of the correct procedure to be used to summon specialist help
- The need to have all Trust resuscitation trolleys equipped with surgical airway equipment
- All staff to be involved in checking the emergency equipment stored on a unit/ward in order that items are easy to find/locate in an emergency
- Consider allergic reaction with any ambiguous patient history and consider anaphylaxis as a differential diagnosis
- Importance of recording lying and standing blood pressures in line with the Trust falls policy and the importance of pre/post fall care planning as well as regular fall risk reassessment
- The need to ensure that verbal conversations between both interprofessional teams and patients are recorded accurately on e-Care
- The need for greater staff awareness of the principles of information governance, emphasising the importance of not accessing patient records unless they have a clinical need to
- e-Care, and IT systems in general, play an important role in mitigating against human error through automation, computerisation and functions within systems
- Importance of listening to the information given to staff from both patients and their families regarding previous medical history, treatment and concerns they may have.

During 2018/19, there were two **never events** reported (one in 2017/18) and subject to detailed investigation.

(a) Wrong site (anaesthetic) block - prior to surgery for a left hip hemiarthroplasty it was identified that the anaesthetist had administered the anaesthetic block to the wrong side. Following identification of error, the operation continued as planned. The patient did not come to any additional harm as a consequence of the incident apart from a requirement of additional opioids for pain relief.

The National Safety Standards for Invasive Procedures (NatSSIPs) guidance states '*Immediately before the insertion of a regional anaesthetic, the anaesthetist and anaesthetic assistant must simultaneously check the surgical site marking and the site and side of the block*'. In addition the local WSFT safer surgical pathway guidance states '*Where an anaesthetist is planning to perform a regional anaesthetic block whether as part of the anaesthetic technique or as a sole means of anaesthesia, it will be the responsibility of the anaesthetist to mark the site of the proposed block (correct side and site) and document it on the anaesthetic chart. To be done prior to 'sign in'*. Neither guidance was followed on this occasion which was a significant departure from the accepted procedure and directly contributed to the incident. The incident highlighted the need to ensure that there are two people to check the anaesthetic block site, the anaesthetist and the anaesthetic assistant.

It has been agreed that block sites will be marked after the patient has entered the anaesthetic room whilst the World Health Organisation (WHO) check 1 is being read out and then checked again by two members of staff as part of the 'stop before you block' process.

Lessons learned include:

- 'Stop before you block' posters have been reintroduced to all anaesthetic rooms
- Green permanent marker pens have been sourced for anaesthetic use in the anaesthetic room
- Block sites will be marked after the patient has entered the anaesthetic room whilst the WHO check 1 is being read out and then checked again by two members of staff as part of the 'stop before you block' process.

(b) Wrong side breast biopsy - the patient did not suffer any harm as a result of the incident apart from the associated discomfort of the procedure itself which needed to be repeated on the correct side.

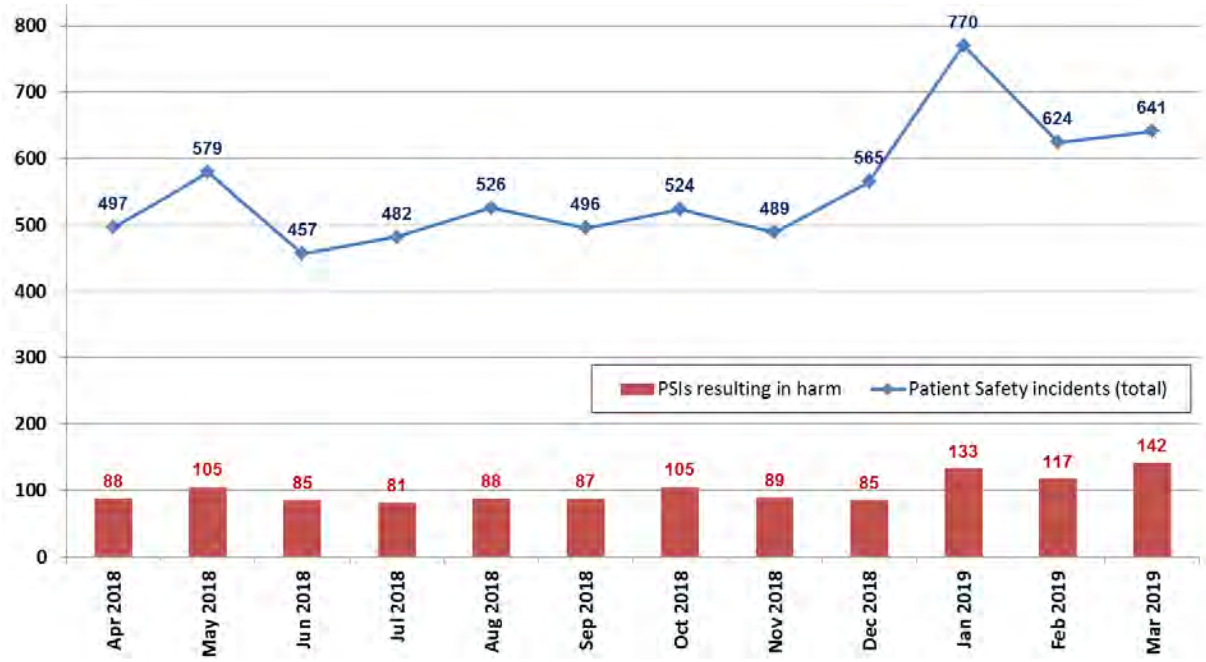
The investigation is ongoing. However immediate mitigating actions included:

- Email to all consultants to remind their respective teams that, prior to any procedure, a minimum of two points of clinical reference (i.e. diagnostic report, referral letter, patients notes) should be reviewed in order to ensure the correct site is identified
- Review roadmap in relation to the publishing of the latest safer surgery pathway
- Review National Safety Standards for Invasive Procedures (NasSSIPs) in relation to this incident and Local Safety Standards for Invasive Procedures (LocSSIPS)
- Explore if a second nurse checker is required.

Patient safety incident (PSI) reporting

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

Patient safety incidents total (line chart) and resulting in harm (bar chart)



Source: Datix

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

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

Duty of candour (DOC)

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

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

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

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

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

Quality walkabouts and executive-led table-top audits

WSFT has a well-established schedule of quality walkabouts attended by executive and non-executive members of the Board and representation from the Trust governors and the CCG.

The walkabouts serve to observe and review real-time care and service delivery in a multitude of settings, including community services, whilst providing staff, patients and visitors with the opportunity to raise issues, concerns or indeed compliments. Formal feedback is provided to the ward manager, service manager and matron. Areas are asked to provide action plans to address issues identified and enable follow-up as part of the quality walkabout process.

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

- Medication security
- Cleanliness and infection control
- Resuscitation trolley checks
- Checking of compliance and displaying up-to-date information
- Escalation plan and resuscitation status (EPARS) completion
- Fluid storage.

Issues identified can range from equipment to staffing skill mix, signage to improvement in documentation and infection prevention to estates. These issues are fed back to the areas, with a view to resolving many issues immediately and escalating any more serious concerns or thematic issues. The quality walkabout process enables staff to raise concerns directly with senior leaders and governors. This has received positive feedback from staff and we continue to plan the programme on a quarterly basis. As well as feeding back the findings to the areas visited, the Board and governors receive a quarterly summary of walkabout activity and learning.

Complementing the walkabouts is an executive-led table-top audit and assurance programme which allows a ‘deep dive’ approach to key patient safety themes and subjects. During 2018/19 these included pressure ulcers, falls, sepsis, mental health and maternity. In 2019/20 this schedule will continue with plans to encompass areas such as VTE (venous thromboembolism), nutrition, AKI (acute kidney injury) and patients with learning disabilities.

Perfect Ward app

WSFT uses the Perfect Ward app for local ward/department inspections. This use of digital technology allows quick, easy and more effective scoring of questions, capture of photographs and free-text comments straight into the app, meaning information is quick to record and up-to-date. Information is stored in the app rather than on the phone used, so it is always secure. Capturing the information directly with phones or tablets means there is no longer a need to write up and send reports afterwards, saving valuable time. As soon as an inspection is complete, everyone with the app can be alerted and see the results. With automated reporting, it is also much easier to compare performance and track improvements at ward level. There are five different audits available in the app; documentation, observation, patient experience, staff and infection prevention and control.

Matrons, ward managers, service managers, general managers, pharmacy, executive directors and the infection prevention team all have access to the Perfect Ward app, and are using it to complete all ward audits at the WSH, Rosemary Ward at Newmarket Community Hospital and the Kings Suite at Glastonbury Court. In 2019/20 this is also being rolled out to the community teams.

Learning from deaths

During 2018/19, 900 WSFT patients died (of which three were neonatal death, four were stillbirths, nine were people with learning disabilities and 13 had a severe mental illness). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 213 in the first quarter (of which one was a neonatal deaths, two were stillbirths, one was a person with learning disabilities and two had a severe mental illness)
- 209 in the second quarter (of which zero were neonatal deaths, one was a stillbirth, two were people with learning disabilities and two had a severe mental illness)
- 219 in the third quarter (of which zero were neonatal deaths, zero were stillbirths, three were people with learning disabilities and three had a severe mental illness)
- 259 in the fourth quarter (of which two were neonatal deaths, one was a stillbirth, three were people with learning disabilities and six had a severe mental illness).

As of 10 May 2019, 774 case record reviews and 31 investigations have been carried out in relation to these 900 deaths. In 31 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 213 case record reviews (seven investigations) in the first quarter
- 209 case record reviews (13 investigations) in the second quarter
- 218 case record reviews (eight investigations) in the third quarter
- 114 case record reviews (three investigations) in the fourth quarter.

One death, representing 0.11% of the patient deaths during the reporting period, was judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- None [0%] for the first quarter
- One [0.48%] for the second quarter
- None [0%] for the third quarter
- None [0%] for the fourth quarter.

No case record reviews and no investigations were completed after 31/03/2018 which related to deaths which took place before the start of the reporting period. These numbers have been estimated using the following pathways: All inpatient deaths excluding neonatal death and stillbirths are collated via the Trust's electronic patient record and recorded on a bespoke mortality database (Rhapsody). Neonatal deaths and stillbirths are collated via the MBRRACE-UK perinatal mortality surveillance system. Deaths of patients with a learning disability are recorded on Rhapsody but also reported to the national learning disabilities mortality review programme (LeDeR). Maternal deaths are also reported to the Healthcare Safety Investigation Branch (HSIB) for external review.

A case record review is undertaken using the Royal College of Physicians' structured judgement review (SJR) method. The objective of the SJR method is to look for strengths and weaknesses in the caring process, 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. Bereaved families are invited to give feedback on the care their relative received. In a small number of cases a further investigation is warranted and this is undertaken via the Trust's incident reporting pathway. Case record reviews and investigations conducted have highlighted the following themes:

- Many examples of excellent communication with family and relatives by junior doctors, when explaining care and treatment
- Regular comment upon the excellent care provided by the palliative care team
- Delayed recognition that a patient is reaching the end of their life, such that active treatment continues when, with the benefit of hindsight, it was likely to be futile
- Continuing active treatment also when it has been recognised that the patient is dying, and they and their family have agreed a plan for palliative care with the ward team. Unfortunately, sometimes active treatment still continues, which could impact on the patient's quality of life in their last few days
- In addition, the publication in 2018 of the 2016 National MBRRACE summary report and UK Perinatal Mortality Report noted a slightly increased stillbirth rate at WSFT. This trend had

already been identified internally in 2016 and been the subject of thematic review with changes implemented at the time and subsequently in 2017-19 including:

- Actions to address the issues of women who smoke in pregnancy, including participation in the national 'MatNeo' patient safety initiative (see 'Performance against 2018/19 priorities' section for more details)
- Checks undertaken at routine antenatal appointments such as urine testing and confirmation that women are taking folic acid
- Implement multiple pregnancy clinic in line with the guidance of NICE (CG129 *Multiple pregnancy: antenatal care for twin and triplet pregnancies*)
- Guidance on referral pathway to fetal medicine.

The Trust identified its first case of a maternal death for review by the HSIB in 2018/19. The investigation is still ongoing at the time of this report.

Whilst the Trust records and reviews deaths of patients with a learning disability, it does not currently receive feedback from the external LeDeR review and will be actively seeking this to enhance wider learning in 2019/20. Actions taken in 2018/19 as a consequence of what has been learned during 2018/19 include:

- Audit of completion of escalation plan and resuscitation status (EPARS) forms in the electronic patient record
- Quality improvement project on the importance of maintaining steroid medication
- Last days rounding tool to be included in the Trust-wide nursing documentation review
- Service user involvement in learning from deaths committee, ensuring learning into action is progressed
- Trust-wide, multidisciplinary, quarterly learning events including cases identified by learning from deaths
- Positive feedback for excellent care at ward and individual level.

Actions proposed to be taken in 2019/20 as a consequence of what has been learned during 2018/19 include:

- Quality improvement project on the implementation of the amber care bundle for end-of-life care, supported by the hospice
- Improvement of EPARS completion will be addressed as part of a suite of interventions to improve patient flow, as a Trust-wide quality priority
- Continue to work on ways to improve serial scans for women who smoke
- Development of the opportunities for learning from external reviews from LeDeR
- Widen the involvement of service users in the learning from deaths committee
- Continue to develop wider shared learning pathways including electronic newsletters, case presentation to committees and ward folders (led by the patient safety team).

Reflecting on the actions taken in 2018/19, our approach to learning from deaths continues to evolve and we are actively looking for ways in which to measure impact. In particular, we are looking for ways to measure improvements more agilely and less resource intensively than relying on manual audit. It is likely that our electronic patient record system can support this. We are also working with our family representative and patient experience manager to consider how family members could help us measure impact, and how we could employ qualitative methods when numbers would not be informative.

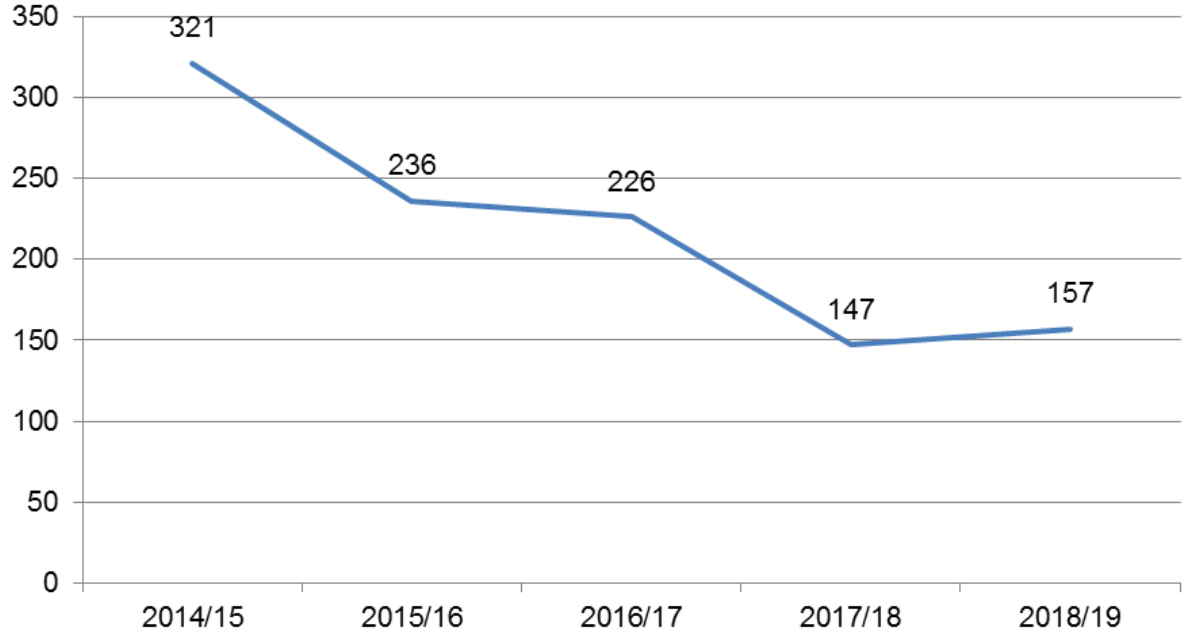
Complaints management

WSFT is committed to providing an accessible, fair and effective means of communication for those persons who wish to express their concerns with regard to the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the six principles for remedy as published in October 2007 by the Parliamentary and Health Service Ombudsman (PHSO).

Complaints are reviewed with service managers, associate directors, clinical directors and matrons to ensure that learning takes place, issues are addressed and trends identified. Examples of learning are detailed below. Themes and lessons learned are also reviewed by the patient and carer experience group and patient experience committee.

WSFT received 157 formal complaints during 2018/19. This is in line with numbers received in 2017/18 (an increase of ten) and a maintained decrease in comparison to earlier years, as demonstrated below. The Board monitors complaints and learning on a monthly basis as part of the quality reporting arrangements.

Number of formal complaints received

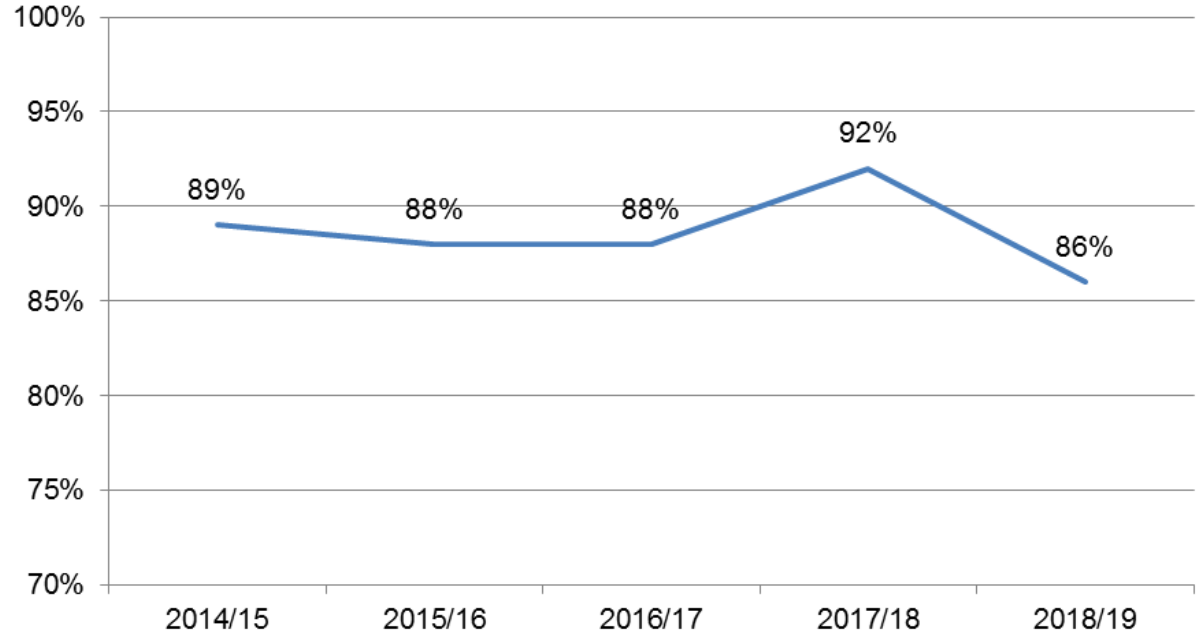


Source: Datix

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 2018/19 the Trust successfully resolved 135 complaints at first stage, with 22 investigations escalating to second stage throughout the year.

Complaints closed at first stage



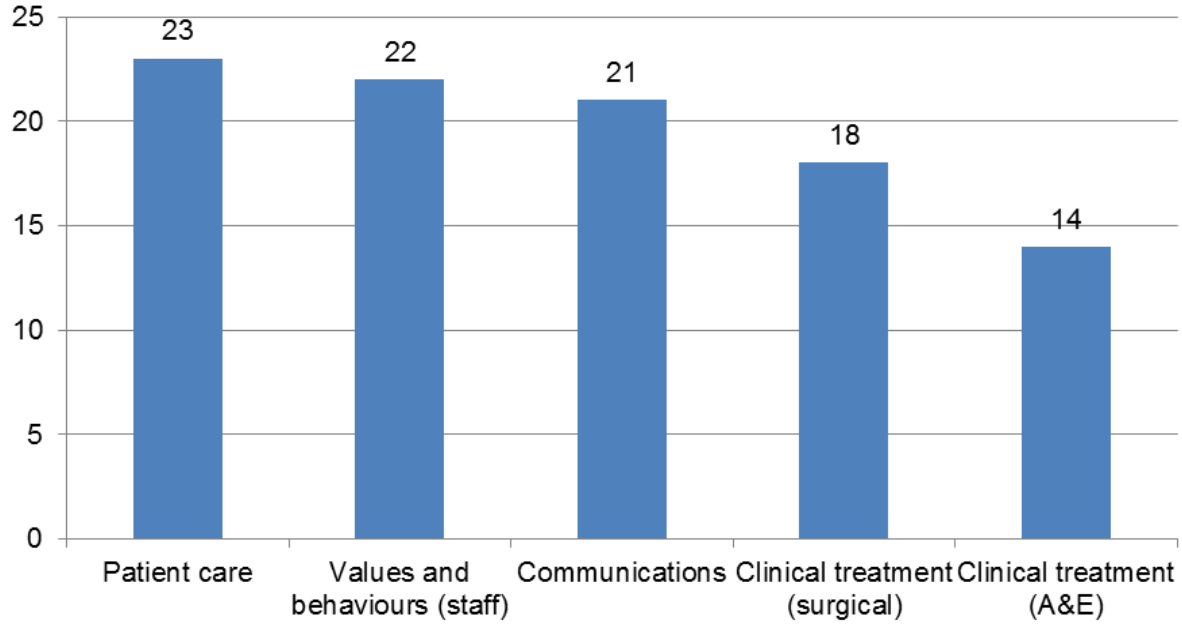
Source: Datix

Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2018/19, four complaints were referred to the PHSO, compared to seven during 2017/18.

In 2018/19, the PHSO completed its review of two complaints. Both were deemed not to be upheld therefore no recommendations were made.

Despite a reduced resolution rate at first stage, the decrease of complaints accepted for investigation by the PHSO in 2018/19 demonstrates robust investigation processes at local level.

Top five primary categories of complaints



Source: Datix

The numbers identified in the chart above list only primary concerns; many complaints have multiple categories. The top five categories remain the same as the previous financial year,

with patient care still being the top category for concern. Values and behaviours has moved from the fifth most common category in 2017/18 (11 complaints) to the second in 2018/19. Both categories of clinical treatment have moved from second and third most common to fourth and fifth.

Upon investigation the most common sub-category of patient care was care needs not adequately met (14). Of those that have completed their investigation at the time of this report, four were deemed not to be upheld and four partially upheld. One was fully upheld.

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

- Mental health awareness training for ward staff
- Improvements in patient record system, allowing access to manage duplicate registrations of patients, avoiding errors
- Signage improvements across the car parks
- Wider selection and stock of neck braces on surgical wards to cater for individual patient needs
- Improvements to stock of first aid in imaging services.

There were a number of 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 646 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 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.

Inpatient survey 2017

Inpatient services scored significantly better than other organisations on the question 'Did hospital staff discuss with you whether additional equipment or adaptions were needed in your home?'.

Overall the Trust performed was as follows:

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Overall views of care and services						
S10 Section score	4.4	3.8	6.0			
Q67 Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.2	8.5	9.7	509	9.2	
Q69 During your hospital stay, were you ever asked to give your views on the quality of your care?	1.6	0.7	3.6	446	1.2	
Q70 Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.6	1.4	5.1	366	2.6	
Overall experience						
S11 Section score	8.3	7.5	9.2			
Q68 Overall...	8.3	7.5	9.2	493	8.3	

The 2018 patient survey results will not be available until summer 2019.

Maternity survey 2018

Maternity services scored significantly better than other organisations on five questions:

- If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- Did the staff treating and examining you introduce themselves?
- Thinking about your care during labour and birth, were you spoken to in a way you could understand?
- Were you given information or offered advice from a health professional about contraception?
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around six to eight weeks after the birth).

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

National staff survey 2018

The WSFT has seen a slight increase in the response rate in the latest staff survey results. The Trust maintains the above average score in staff engagement of 7.4 against the national average of 7.0.

The Trust has been benchmarked against acute trusts nationally and has the highest scores where staff feel they have a choice in deciding how to do their work scoring 61.1% compared to the average of 54%, and where staff have not felt pressure from their manager to come to work despite feeling unwell, with a score of 19.1% against the average of 25.9%.

There have been significant improvements in staff receiving an appraisal in the last 12 months which has increased from 74.7% to 87.9%; as well as them feeling that their work was valued by the organisation, which has increased from 30.8% to 39.6%; and organisational values were discussed, which has increased from 19.9% to 32.5%.

There have also been areas which have deteriorated, such as the reporting of experiences of physical violence and harassment/bullying/abuse, the reporting of these has reduced from 65.2% to 49.7% and 51.2% to 37.9% respectively. There has also been a reduction in staff who have observed an error, reporting a near miss or an incident that could have harmed a patient/service user, where we scored 91.4% against the average of 95%.

Workforce Race Equality Standard (WRES)

The scores presented below are the unweighted scores for indicators 5, 6, 7 and 8 split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

		WSFT 2018	Average (median) for acute trusts	WSFT 2017
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	**27%**	28%	27%
	BME	**21%**	30%	42%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	**23%**	26%	19%
	BME	**34%**	29%	30%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	**90%**	87%	89%
	BME	**79%**	72%	82%
In the last 12 months have you personally experienced discrimination at work from any of the following – Manager/team leader or other colleagues?	White	**7%**	7%	6%
	BME	**11%**	15%	16%

3.7 Development of the quality report

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

During 2018/19 we have built on our understanding of the views of Trust members' and users' quality priorities through FT membership engagement events. The results of this feedback are reflected in the format and content of this quality report.

In preparing the quality report, we also sought the views of West Suffolk CCG, Suffolk Health Scrutiny Committee, Healthwatch Suffolk and our governors.

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

Annex A: Participation in clinical audit

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

Table A: National clinical audits

National clinical audit	Host organisation	Eligible	Participated	%
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Adult Community Acquired Pneumonia	British Thoracic Society (BTS)	Yes	Yes	Ongoing[1]
BAUS Urology Audit – Cystectomy	British Association of Urological Surgeons (BAUS)	No	N/A	-
BAUS Urology Audit – Female Stress Urinary Incontinence	British Association of Urological Surgeons (BAUS)	Yes	Yes	Ongoing[1]
BAUS Urology Audit – Nephrectomy	British Association of Urological Surgeons (BAUS)	Yes	Yes	Ongoing[1]
BAUS Urology Audit – Percutaneous Nephrolithotomy	British Association of Urological Surgeons (BAUS)	Yes	Yes	Ongoing[1]
BAUS Urology Audit – Radical Prostatectomy	British Association of Urological Surgeons (BAUS)	No	N/A	-
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing[1]
Elective Surgery (National PROMs Programme)	Health & Social Care Information Centre (HSCIC)	Yes	Yes	Ongoing[1]
Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians	Yes	Yes	Ongoing[1]
Feverish Children (Care in Emergency Departments)	Royal College of Emergency Medicine	Yes	Yes	100
Inflammatory Bowel Disease (IBD) Registry	Inflammatory Bowel Disease Registry	Yes	No[2]	Ongoing[1]
Learning Disability Mortality Review Programme (LeDeR Programme)	University of Bristol	No	N/A	-
Major Trauma Audit	Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing[1]
Mandatory Surveillance of Bloodstream Infections and Clostridium *Difficile* Infection	Public Health England	Yes	Yes	Ongoing[1]
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing[1]
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing[1]
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	No	N/A	-
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing[1]
National Asthma and COPD Audit Programme	Royal College of Physicians	Yes	Yes	Ongoing[1]

National clinical audit	Host organisation	Eligible	Participated	%
National Audit of Anxiety and Depression	Royal College of Psychiatrists	No	N/A	-
National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Audit of Cardiac Rehabilitation	University of York	Yes	Yes	Ongoing[1]
National Audit of Care at the End-of-Life (NACEL)	NHS Benchmarking Network	Yes	Yes	100
National Audit of Dementia	Royal College of Psychiatrists	Yes	Yes	100
National Audit of Intermediate Care	NHS Benchmarking Network	Yes	Yes	100
National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	No	N/A	-
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	No	N/A	-
National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology (BSR)	Yes	Yes	Ongoing[1]
National Clinical Audit of Psychosis	Royal College of Psychiatrists	No	N/A	-
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	King's College London / London North West Healthcare NHS Trust	No	N/A	-
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Yes	Yes	100
National Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
National Diabetes Audit – Adults	NHS Digital	Yes	Yes	Ongoing[1]
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Yes	Yes	Ongoing[1]
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing[1]
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	Ongoing[1]
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	100
National Mortality Case Record Review Programme	Royal College of Physicians	Yes	N/A	-
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing[1]
National Audit of Oesophago-Gastric Cancer (NAOGC)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Ophthalmology Audit	Royal College of Ophthalmologists	Yes	No[3]	-
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	100
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons	Yes	Yes	Ongoing[1]

National clinical audit	Host organisation	Eligible	Participated	%
National Vascular Registry	Royal College of Surgeons of England	Yes	Yes	Ongoing[1]
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	No	N/A	-
Non-Invasive Ventilation – Adults	British Thoracic Society	Yes	Yes	Ongoing[1]
Paediatric Intensive (PICANet)	University of Leeds	No	N/A	-
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	No	N/A	-
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Public Health England	Yes	Yes	Ongoing[1]
Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Royal College of Physicians	Yes	Yes	Ongoing[1]
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Serious Hazards of Transfusion	Yes	Yes	Ongoing[1]
Seven Day Hospital Services	NHS England	Yes	Yes	100
Surgical Site Infection Surveillance Service	Public Health England	Yes	Yes	Ongoing[1]
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	N/A	-
Vital Signs in Adults (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100

1 Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2018/19 is currently unavailable.

Table B: Clinical outcome review programmes participation

Clinical outcome review programme	Host organisation	Eligible	Participated	%
Maternal Mortality and Morbidity Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Maternal Mortality Surveillance Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Perinatal Mortality and Morbidity Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Perinatal Mortality Surveillance Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Cancer in Children, Teens and Young Adults (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	No	No	-
Long Term Ventilation (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing[1]
Perioperative Diabetes (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Pulmonary Embolism (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing[1]

Clinical outcome review programme	Host organisation	Eligible	Participated	%
Acute Bowel Obstruction (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing[1]
Management and Risk of Patients with Personality Disorder Prior to Suicide and Homicide	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	No	No	-
Suicide, Homicide and Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	No	No	-
Suicide in Children and Young People	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	No	No	-

1 Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2018/19 is currently unavailable
2 The National Ophthalmology Audit requires the use of Medisoft software, which is incompatible with e-Care. The Open Eyes platform was agreed as a solution to facilitate participation as part of the proposed work schedule of the Global Digital Excellence funding programme. This was implemented in January 2019. It has been agreed that there will be a time frame of six months to collect data for the National Ophthalmology Audit prior to submission. Full participation will be achieved by July 2019
3 The Inflammatory Bowel Disease (IBD) Registry initially could not be supported by the gastroenterology team as they were already completing the IBD Management Software for patients. The team has now mapped across the data requirements and is planning to complete IBD Registry from the start of the new financial year.

Table C: Action from national clinical audit reports

National clinical audit	Summary of actions taken
National Ophthalmology Database Audit (NOD) 2018	Recommendations reviewed by the ophthalmology clinical lead. The National Ophthalmology Audit requires the use of Medisoft software, which is incompatible with e-Care. The Open Eyes platform was agreed as a solution to facilitate participation as part of the proposed work schedule of the Global Digital Excellence funding programme. This was implemented in January 2019. It has been agreed that there will be a timeframe of six months to collect data for the National Ophthalmology Audit prior to submission. Full participation will be achieved by July 2019.
National Audit of Breast Cancer in Older Patients (NABCOP) 2018 Annual Report	Recommendations reviewed by the breast cancer team. All recommendations met and no further actions identified.
National Paediatric Diabetes Audit (NPDA) Report 2016/17	Recommendations reviewed by the paediatric diabetes team. All recommendations met and no further actions identified.
National Audit of Dementia (NAD) 2018 report	National Audit report reviewed by the lead nurse for dementia/frailty. Following report publication it was identified that the cognitive screening and assessment box was not easily accessible for doctors. The dementia/frailty team has agreed to work with the e-Care team to ensure that the Screening form is included within clinical clerking proforma pages and the CGA template. Additional action taken to request a daily dementia/ delirium report, as well as a monthly report identifying AMTS and 4AT scoring. Following the audit, it was also identified that initial screening is often completed but recorded in clerking notes rather than assessment box. The e-Care team is to launch SmartZone banner rather than pop-up alert – stating complete dementia/delirium assessment provision of tier 1 dementia training programme. Delirium to be included in future Mandatory training.
Procedural Sedation in Adults RCEM 2017/18 Audit	Recommendations reviewed by an emergency department consultant. Action taken to ensure that ECG monitoring is recorded in e-Care and to ensure incorporation of discharge advice into e-Care.
Pain in Children RCEM 2017/18 Audit	Recommendations reviewed by an emergency department consultant. Action taken to ensure re-evaluation of pain after analgesia. Following review it was agreed for the paediatric safety checklist to be amended.
National COPD Audit Programme: Resources and Organisation of Care in Hospitals 2017	Recommendations reviewed by a respiratory consultant. The Trust is currently in the process of reviewing the complement of COPD nurses to better achieve service recommendations. Action taken to employ new specialist nurse/physician.

National clinical audit	Summary of actions taken
National COPD Audit Programme: Clinical Audit of COPD Exacerbations Admitted to Acute Hospitals 2017	Recommendations reviewed by a respiratory consultant. The Trust has identified a need for an inpatient COPD team. Action taken to employ new specialist nurse/physician.
National Prostate Cancer Audit (NPCA) 2018 Report	Recommendations reviewed by the prostate cancer team. All recommendations met and no further actions identified.

Local audit report summary actions are detailed on the WSFT website:
https://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Annual-reports.aspx

Annex B: Nationally-mandated quality indicators

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

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

Summary hospital-level mortality indicator (SHMI)

	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18
WSFT (control limits)	93.49 (98.41 to 88.75)	89.76 (84.9 to 94.83)	89.29 (92.48 to 89.05)	87.89 (107.71 to 92.69)
Banding [1]	-	-	2	3
National average	100	100	100	100.35
Highest NHS trust	120.89	115.63	122.77	125.72
Lowest NHS trust	66.05	62.59	72.61	69.82

Source: Dr Foster up to June 17, NHS Digital July 17 onwards

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

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

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

	Jul 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Oct 17 – Sep 18
WSFT	26.34%	19.71%	32.54%	31.1%	41.0%
National average	24.79%	26.31%	29.56%	35.9%	33.6%

Source: Dr Foster to June 17, NHS Digital October 17 onwards

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

(b) Patient reported outcome measures scores (PROMS)

	2014/15	2015/16	2016/17	2017/18 (Apr – Sep 17)	2018/19
Groin hernia surgery					
WSFT (EQ-5D Index)	0.111	0.128	0.111	0.139	Data not published
National average (EQ-5D Index)	0.084	0.088	0.086	0.089	
Varicose vein surgery					
WSFT (EQ-5D Index)	0.052	0.081	-0.019	0.116	Data not published
National average (EQ-5D Index)	0.095	0.095	0.092	0.096	
Hip replacement surgery (primary)					
WSFT (EQ-5D Index)	0.427	0.490	0.455	0.538	Data not published
National average (EQ-5D Index)	0.437	0.438	0.445	0.468	
Knee replacement surgery (primary)					
WSFT (EQ-5D Index)	0.327	0.287	0.338	0.427	Data not published
National average (EQ-5D Index)	0.315	0.320	0.324	0.338	

Source: NHS Digital. Groin and Varicose vein data for 2017/18 is up to September 17. Hip and Knee data is for the full financial year

WSFT considers that this data is as described as PROMS data is issued quarterly. All results are reviewed to ensure that plans are in place to systematically deliver good performance. The 2017/18 data remains provisional and may be based on small sample sizes.

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

	2014/15	2015/16	2016/17	2017/18	2018/19
Aged 0 to 15	5.75%	6.88%	-	-	-
Aged 16 or over	15.50%	16.68%	-	-	-

Source: 2014-16: WSFT patient administration system (PAS)
2016/17 and 2018/19 – unable to report data

WSFT considers that this data is as described. No comparative national data is available for the periods reported. WSFT will continue to review readmissions and identify themes arising from the information gained. The launch of e-Care in May 2016 impacted on our ability to report performance against a number of quality standards, including readmissions. We are working with our digital partner, Cerner, to deliver further improvements to reporting to enable full reporting of this data.

(d) Responsiveness to the personal needs of its patients

	2015	2016	2017	2018
WSFT	70.2	72.9	69.7	68.6
National average	68.9	69.6	68.1	68.6
Highest NHS trust	86.1	86.2	85.2	85.0
Lowest NHS trust	59.1	58.9	60.0	60.5

Source: NHS Digital

WSFT considers that this data is as described as each year WSFT participates in a national inpatient survey. Review of this data shows that WSFT is performing at the national average and has performed better than the national average in three of the last four years.

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

If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	2016	2017	2018
WSFT (agree + strongly agree)	84.8	85.3	82.9
England: acute trusts (agree + strongly agree)	69.1	70.8	71.3
Benchmark group best result (agree + strongly agree)	84.8	85.3	87.3
Benchmark group worst result (agree + strongly agree)	48.9	46.7	39.8

Source: National NHS Staff Survey Co-ordination Centre - Picker Institute

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

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

	2014/15	2015/16	2016/17	2017/18	2018/19
WSFT	99.63%	99.46%	86.62%	92.12%	94.94%
National average	96.09%	95.76%	95.61%	95.27%	95.59%

Source: NHS England

WSFT considers that this data is as described. WSFT has taken a range of actions to improve performance and these are set out in the 'Performance against 2018/19 priorities' section of this report.

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

	2014/15	2015/16	2016/17	2017/18	2018/19
WSFT	16.3	16.4	17.3	13.4	Not yet published
National average	15.0	14.9	13.2	13.7	Not yet published

Source: Health Protection Agency (HPA)

WSFT considers that this data is as described as the *C. difficile* infection cases is consistent with the data reported to the Board on a monthly basis and described in the 'Other quality indicators' section of this report.

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

Patient safety incidents (total)

	WSFT number and rate/1000 bed days	Median (all acute non-specialist trusts) Rate/1000 bed days	Comparison to peer group
Apr 2016 – Sept 2016	2,517 (36.2 / 1000 bed days)	40.02 / 1000 bed days	Middle 50% of trusts
Oct 2016 – Mar 2017	2,617 (36.39 / 1000 bed days)	40.14 / 1000 bed days	Middle 50% of trusts
Apr 2017 – Sept 2017	2,541 (35.78 / 1000 bed days)	42.84 / 1000 bed days	Middle 50% of trusts
Oct 2017 – Mar 2018	2,877 (39.53 / 1000 bed days)	42.55 / 1000 bed days	Middle 50% of trusts
Apr 2018 – Sept 2018	2,642 (39.3 / 1000 bed days)	44.52 / 1000 bed days	Middle 50% of trusts
Oct 2018 – Mar 2019	3,624*	Not yet published	Not yet published

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

In October 2017 the Trust took on responsible for the delivery of community services, this has contributed to an increase in the number of reported patient safety incidents.

Patient safety incidents resulting in severe harm or death

	WSFT number and % of total reported	Average (all acute non-specialist trusts) % of total reported	Comparison to peer group
Apr 2016 – Sept 2016	12 (0.5%)	0.4%	Above peer group average
Oct 2016 – Mar 2017	20 (0.7%)	0.4%	Above peer group average
Apr 2017 – Sept 2017	13 (0.5%)	0.35%	Above peer group average
Oct 2017 – Mar 2018	16 (0.5%)	0.3%	Above peer group average
Apr 2018 – Sept 2018	15 (0.6%)	0.34%	Above peer group average
Oct 2018 – Mar 2019	15 (0.4%)*	Not yet published	Not yet published

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

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

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

Annex C: Comments from third parties

WSFT Council of Governors

The Council of Governors, with support from the Board and Trust management, continues to embrace its role to represent both the interests of the Trust as a whole and the interests of the population that it serves. The Governors recognise and fully support the Board of Directors' commitment to improving the already high standard of care for our patients.

The Governors are keen to harness the power of our local community and use the Trust's position in west of Suffolk health and care system to promote and integrate services for the local population.

A good working relationship exists between the governors and board which encourages the constructive contribution of the governors. During 2018/19 we have strengthened our work through:

- **Engagement with members and public:**
  - Regular contact with patients and their supporters
  - Capturing feedback at the patient and visitor cafes in West Suffolk Hospital and Newmarket Hospital, sharing this with hospital management and receiving feedback on action taken
  - Encouraging the public to join as members of the Foundation Trust and engaging with approximately 6,000 public members to take an interest in the hospital
  - Providing support for planning and delivery of external public meetings and events, including annual members meeting and medicine for members.

- **Review of care and services provided:**
  - Taking part in 'Quality Walkabouts' enables Governors to talk to staff (and patients) about implementation of changes and what actions have or have not been followed up.
  - Taking part in 'Environmental Reviews' enables Governors to view the hospital and community facilities from a viewpoint of patients and visitors, such as matters of cleanliness, ease of access, direction boards and information panels/notices.
  - Taking part in 'Area Observations' enables Governors to observe the environment, general atmosphere, staff interactions and anything else they feel is enhancing or adversely affecting patient experience. This information is fed back to the manager and an action plan monitored through the patient and carer experience group.

- **Working with the board:**
  - Regular attendance at Trust Board meetings, where we are encouraged to ask questions and report back to all Governors on outcomes of these discussions
  - Attending Board meetings has also educated Governors on key clinical areas and developments
  - Working with the non-executive directors (NEDs) a two way exchange of intelligence gathered and areas for improvement
  - Regular workshops focused on key developments within the operational plan
  - Completed on schedule the appraisals of all NEDs
  - Holding the board to account through the NEDs by requesting assurance on areas of concern; such as pathology services as well as quality, operational and financial performance
  - During 2018-19 appointed one new NED.

- **Development of knowledge and skills:**
  - Agreed a training and develop programme, including an externally facilitated session
  - Attended training events, both internal and external to support learning and development
  - Held informal meetings of Governors, arranged by the Lead Governor, to ensure effective working relationships and preparations for meetings.

We recognise the contribution made by the staff and volunteers and would like to thank them for their dedication and hard work which makes the West Suffolk Hospital and our community services very special for our patients, the public and staff.

The governors recognise the importance of the evolving West Suffolk Alliance in the delivery of health and care services in the west of Suffolk. The governors recognise the importance of developing their relationship with patients and staff that utilise and serve these services outside the West Suffolk Hospital.

West Suffolk Clinical Commissioning Group

West Suffolk Clinical Commissioning Group, as the commissioning organisations for West Suffolk NHS Foundation Trust, confirm that the Trust has consulted and invited comment regarding the Quality Account for 2018/2019. This has occurred within the agreed timeframe and the CCGs are satisfied that the Quality Account incorporates all the mandated elements required.

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

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

This Quality Account demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Groups endorse the publication of this account.

Lisa Nobes
Chief Nursing Officer

Suffolk Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2018/19. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. The Committee has taken the view that it would be appropriate for Healthwatch Suffolk to consider the content of the Quality Accounts for this year, and comment accordingly.

County Councillor Jessica Fleming
Chairman of the Suffolk Health Scrutiny Committee

Healthwatch Suffolk

Healthwatch Suffolk is pleased to have the opportunity to review the 2018/2019 Quality account for the West Suffolk NHS Foundation Trust (WSFT). The Quality Account is presented in a logical and readable manner.

Healthwatch Suffolk is very pleased to see the Trust is investing in high quality, state-of-the-art facilities, notably the £5.2 million cardiac suite. We would also like to highlight the efforts of the Trust's 'My WiSH Charity', which raised a substantial half a million pounds to support the development of the cardiac suite. The Trust expects further improvements of quality in the coming year, with £13.4 million allocated to upgrade the Trust's emergency department.

The Trust has also led the way in the development of their digital quality improvements.

Nevertheless, the Trust has not had an easy year. There have been many challenges due to increased demand. This has resulted in staff feeling pressured, and the movement of staff between

wards has been needed to ensure safe and good care. The Trust is proud of its dedicated and hardworking staff, who they are confident will continue to provide high-quality care for patients.

The Trust has set out three main priorities for the coming year: Patient Flow, Human Factors and Quality Improvements. The reasons given for these choices is clearly explained, and Healthwatch Suffolk believes they have chosen well.

The Trust is required by regulation to make certain statements, and the Trust has complied with the requirement. The Trust has not had a CQC inspection, however, it retains the 'Outstanding' overall rating which it achieved in 2017/2018. The Trust has received a good number of awards and accolades, notably some fifty women from across the Trust being announced as Inspirational Women of West Suffolk.

The Trust's performance for 2018/2019 is reported against their quality priorities. The priorities were:

1. Deliver personal care: Deliver measurable improvements in the patient experience.
2. Deliver safe care: Set goals and measure quality improvement, for key indicators of care.
3. Deliver joined-up care: Explore and develop more effective models of care, engaging with our partners and community.
4. Support a health start: Promote a healthy pregnancy and ensure every child has the best start in life.
5. Support all our staff: Support all our staff to flourish and learn whilst delivering high quality services.

The Trust has carried out a considerable amount of work in the attempt to achieve these goals. They have had a lot of success, though more needs to be done. WSFT also reports results against national targets, and they have had difficulty in achieving several of the cancer targets (whereas in previous years they had enjoyed much greater success). They report patient safety incidents, and these are reviewed by the Trust's board on a monthly basis. The number of formal complaints received by the Trust has fallen steadily since 2014/15, though there was a slight uptick in 2018/19.

Information received by Healthwatch Suffolk

Healthwatch collects data from members of the public using four Community Development officers and their website's Feedback Centre.

The number of service reviews recorded in 2018/9 was 206. 56% were positive reviews while 18% were negative, with the remainder being neutral.

Overall, patient feedback has been similar to the previous period – while the feedback speaking positively of West Suffolk Hospital has remained largely the same level, the proportion rated negative has seen a reduction.

On a general level across all departments, the most positive feedback praised the staff attitudes, the treatment and care (particularly patient experience and the explanations and advice given), as well as a general unspecified acknowledgement of the service.

On the negative side of the scale, discharge experiences were strongly criticised, with patients citing issues with the preparation of discharge and a lack of information being provided. The hospital's ability to communicate effectively was also criticised.

Healthwatch Suffolk looks forward to working with West Suffolk NHS Foundation Trust in the future. The Trust is a good hospital as reflected in its CQC rating of 'Outstanding'. However, in any hospital, improvements can be made.

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

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

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

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2018 to 24 May 2019
    - papers relating to quality reported to the Board over the period April 2018 to 24 May 2019
    - feedback from commissioners dated 16/5/19
    - feedback from governors dated 13/5/19
    - feedback from local Healthwatch organisations dated 17/5/19
    - feedback from Overview and Scrutiny Committee dated 25/4/19
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 9/5/19
    - the 2017 national patient survey 13/6/18
    - the 2018 national staff survey 26/2/19
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 17/4/19
    - CQC inspection report dated 23/01/2018
- the quality report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Sheila Childerhouse
Chair
28 May 2019

Dr Stephen Dunn
Chief executive
28 May 2019

Annex E: Independent auditor's report to the council of governors of West Suffolk NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of West Suffolk NHS Foundation Trust to perform an independent assurance engagement in respect of West Suffolk NHS Foundation Trust's Quality Report for the year ended 31 March 2019 ("the Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

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

Directors' responsibilities

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibilities

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Requirements for External Assurance for Quality Reports 2018/19 issued by NHS Improvement in December 2018 ("the Guidance"); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from commissioners, dated May 2019;
- feedback from governors, dated May 2019;
- feedback from local Healthwatch organisations, dated May 2019;
- feedback from the Overview and Scrutiny Committee dated May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019;

- the latest national patient survey, dated June 2018;
- the latest national staff survey, dated 2018;
- Care Quality Commission inspection, dated 23 January 2018; and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2019.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of West Suffolk NHS Foundation Trust as a body, in reporting West Suffolk NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and West Suffolk NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for External Assurance for Quality Reports 2018/19 issued by NHS Improvement in December 2018; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

BDO LLP
Chartered Accountants
Ipswich, UK

28 May 2019

Annex F: Glossary

Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) has now replaced the term acute renal failure and a universal definition and staging system has been proposed to allow earlier detection and management of AKI.

Clostridium *difficile*

C. difficile is a spore-forming bacterium which is present as one of the normal bacteria in the gut of up to 3% of healthy adults. People over the age of 65 are more susceptible to developing illness due to these bacteria.

C. difficile diarrhoea occurs when the normal gut flora is altered, allowing *C. difficile* bacteria to flourish and produce a toxin that causes a watery diarrhoea. Procedures such as enemas and gut surgery, and drugs such as antibiotics and laxatives cause disruption of the normal gut bacteria in this way and therefore increase the risk of developing *C. difficile* diarrhoea.

CQC

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

The CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

CQUIN

The Commissioning for Quality and Innovation (CQUIN) payment framework enables our commissioner, NHS Suffolk, to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

DEXA (DXA) scan

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

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

Dr Foster Intelligence

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

EPARS

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

EPRO	EPRO is a web-based clinical information management system which supports deployment of discharge summaries while also managing patient records and providing reporting capabilities.
HSMR	Hospital standardised mortality ratio (HSMR) is calculated as a ratio of the actual number of deaths to the expected number of deaths among patients in acute care hospitals. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate; greater than 100 suggests that the local mortality rate is higher than the overall average; and less than 100 suggests that the local mortality rate is lower than the overall average.
MEWS	Modified early warning score (MEWS) is a simple physiological scoring system suitable for use at the bedside that allows the identification of patients at risk of deterioration.
NHSI	NHS Improvement (NHSI) is the sector regulator for health services in England. NHSI's job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. NHSI exercises a range of powers granted by Parliament which includes setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences issued to NHS-funded providers.
MRSA	MRSA (*Methicillin Resistant Staphylococcus Aureus*) is an antibiotic-resistant form of a common bacterium called Staphylococcus aureus. *Staphylococcus aureus* is found growing harmlessly on the skin in the nose in around one in three people in the UK.
NCEPOD	National confidential enquiry into patient outcome and death (NCEPOD). NCEPOD promotes improvements in healthcare. They publish reports derived from a vast array of information about the practical management of patients.
Never event	Never events are a sub-set of SIRIs and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.
NRLS	The national reporting and learning system is a national database of confidentially-reported patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.
PROMs	Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre- and post-operative surveys.
Quality Walkabouts	A programme of weekly visits to wards and departments by Board members and governors. These provide an opportunity to talk to

staff about quality and test arrangements to deliver WSFT's quality priorities.

RCA

A root cause analysis (RCA) is a structured investigation of an incident to ensure effective learning to prevent a similar event happening.

Red2Green

Sometimes patients spend days in hospital that do not directly contribute towards their discharge, we believe that by working better together we can reduce the number of these 'red days' in favour of value-adding 'green days'.

SAFER

The SAFER patient flow bundle blends five elements of best practice. It's important to implement all five together for cumulative benefits and it works particularly well when you use it with the 'Red2Green days' approach. The five elements of the SAFER patient flow bundle are:

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.

Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm-free care. As well as recording pressure ulcers, falls, catheters with urinary tract infections (UTIs) and VTEs, additional local information can be recorded and analysed.

Sepsis

In sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced.

If not treated quickly, sepsis can eventually lead to multiple organ failure and death.

'**Sepsis Six'** is a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring - to be instituted within one hour by non-specialist practitioners at the front line.

SHMI

Summary hospital-level mortality indicator (SHMI) is the ratio between the actual number of patients who die following treatment at an acute care hospital and the number that would be expected

	to die on the basis of average figures across England, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.
SIRI	Serious incidents requiring investigation (SIRIs) in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.
VTE	Venous thromboembolism, or blood clots, are a complication of immobility and surgery.

West Suffolk NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Contents Page

Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by West Suffolk NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Name	**Dr. Stephen Dunn**
Job title	**Chief Executive Officer**
Date	**28/05/2019**

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

Opinion on financial statements

We have audited the financial statements of West Suffolk NHS Foundation Trust (the Trust) for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and as interpreted and adapted by the 2018-19 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2018-19, and the NHS Foundation Trust Annual Reporting Manual 2018-19 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

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

Conclusions relating to going concern

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

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

Key Audit Matters

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

Matter	How we addressed the matter in the audit
Revenue Recognition Most NHS income is subject to reconciliation and formal agreement with other NHS bodies through the Agreement of Balances (AOB) process. There is a risk, however, that other non NHS income and NHS income which is not on block contracts is not completely and accurately reflected in the financial statements, whether as a result of fraud or error. *See Notes 1.4, 3 and 4.*	We substantively tested a sample of material non-NHS income streams to supporting documentation to confirm that income has been accurately recorded and earned in the year. We reviewed the process for resolving discrepancies between the Trust and other NHS bodies through the agreement of balances process, and management's estimate of amounts receivable where there are contract disputes, subsequently investigating all discrepancies and disputed amounts above £300k. We agreed a sample of income with other NHS bodies back to contract amounts. We ensured that all income items tested had been accounted for in line with the Trust's revenue recognition policy.
Fair valuation of Property, Plant and Equipment Property, plant and equipment is the most significant asset in the Trust's balance sheet. At this year end the Trust has undertaken a full valuation of their land and buildings to ensure there is no material misstatement of asset values. The valuation of land and buildings is complex and is subject to a number of assumptions and judgements. A small movement in these assumptions can have a material impact on the financial statements. *See Notes 1.7.2, 7, 12.1 and 13*	We reviewed the instructions provided to the valuer and considered the valuer's skills and expertise in order to determine the extent to which we could rely on Management's expert. We considered whether the basis of valuation used for different classes of assets valued in year was appropriate, based on their usage We reviewed valuation movements against indices of price movements for similar classes of assets and followed up valuation movements that appeared unusual through enquiries made of the Trust and directly with the valuer. We considered the reasonableness of assumptions made by the valuer in forming the valuation and determining the useful economic lives of assets valued using Trust specific sector knowledge and indices.
Deposit Accrual The Trust calculates an accrual for deposits that it has to pay in respect of the hire of Community services equipment, which are due to be returned post year-end. The Trust estimates the accrual using historical collection rate data. We have considered this to be a key audit matter because this figure had a direct impact on the Trust's control total, and the calculation of the accrual is subject to a number of assumptions and judgements. *See Notes 1.2 and 14.1*	We verified the accuracy of the historical recovery rates which were used as the basis for the calculation of the accrual. We obtained external confirmation from the equipment provider to confirm the value of amounts due to be returned as at year-end. We reviewed the assumptions and judgements used to determine the future expected recovery rates and concluded on whether they were appropriate.

Our application of materiality

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

The materiality for the financial statements as a whole was set at £4.45 million (2018 £4.4 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.75%) (2018 - 1.75%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £178,000 (2018- £176,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

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

Other information

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

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

We have nothing to report in this regard.

Opinion on the Remuneration Report and Staff Report

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

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

In our opinion the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2018-19.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion on use of resources

For the year ended 31 March 2019 the Trust reported a deficit of £11.6m after asset impairments of £5.5m (2017/18: deficit of £0.3m).

As at 31 March 2019, the Trust has £97.1m of borrowing, of which £12.2m is required to be repaid in 2019/20, with the only viable plan to re-pay this amount being to take out further borrowings.

The planned deficit control total for 2019/20 set by NHS Improvement is £10.1 million. If achieved, this would give the Trust access to £10.1m of additional funding, achieving a breakeven position. The Trust has agreed to work to this control total.

The Trust does not yet have plans to secure a return to a breakeven cash position in the foreseeable future.

This is evidence of weakness in proper arrangements regarding sustainable resource deployment.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit; or
- the Quality Report has been prepared in accordance with the detailed guidance issued by NHS Improvement.

We also report to you if:

- we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities the Accounting Officer

As explained more fully in the Statement of Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

The Accounting Officer is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

Auditor's responsibilities for the audit of the financial statements

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

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

Auditor's other responsibilities

We are also required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied 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.

Certificate

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

Use of our report

This report is made solely to the Council of Governors of West Suffolk NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of West Suffolk NHS Foundation Trust those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.

BDO LLP

David Eagles
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK

28 May 2019

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

Statement of Comprehensive Income for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	209,723	215,994
Other operating income	4	35,229	36,866
Operating expenses (non-pay)	6	(91,746)	(103,161)
Employee benefits	6	(162,669)	(147,785)
Operating surplus/(deficit) from continuing operations		**(9,463)**	**1,914**
Finance income		64	33
Finance expenses		(1,664)	(1,096)
PDC dividends payable		(957)	(1,067)
Net finance costs		**(2,557)**	**(2,130)**
Other gains / (losses)		111	(71)
Share of profit in joint arrangements		359	-
Deficit for the year		**(11,550)**	**(287)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(264)	-
Revaluations	13	(592)	4,635
Total comprehensive income / (expense) for the period		**(12,406)**	**4,348**

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	11	33,970	23,852
Property, plant and equipment	12	103,223	94,170
Receivables	14	5,054	3,925
Total non-current assets		**142,247**	**121,947**
Current assets			
Inventories		2,698	2,712
Receivables	14	22,119	21,413
Cash and cash equivalents	15	4,507	3,601
Total current assets		**29,324**	**27,726**
Current liabilities			
Trade and other payables	16	(28,341)	(26,135)
Borrowings	17/18	(12,153)	(3,114)
Provisions		(47)	(94)
Other liabilities		(1,207)	(963)
Total current liabilities		**(41,748)**	**(30,306)**
Borrowings	17/18	(84,956)	(65,391)
Provisions		(111)	(124)
Total non-current liabilities		**(85,067)**	**(65,515)**
Total assets employed		**44,756**	**53,852**
Financed by			
Public dividend capital		69,113	65,803
Revaluation reserve		6,931	8,021
Income and expenditure reserve		(31,288)	(19,972)
Total taxpayers' equity		**44,756**	**53,852**

The notes on pages 165 to 187 form part of these accounts.

Dr. Stephen Dunn
Chief Executive
28/05/2019

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**65,803**	**8,021**	**(19,972)**	**53,852**
Deficit for the year	-	-	(11,550)	**(11,550)**
Impairments	-	(264)	-	**(264)**
Revaluations	-	(592)	-	**(592)**
Public dividend capital received	3,310	-	-	**3,310**
Other reserve movements	-	(234)	234	-
Taxpayers' equity at 31 March 2019	**69,113**	**6,931**	**(31,288)**	**44,756**

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

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

Information on reserves

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

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

Income and expenditure reserve
The balance of this reserve is the accumulated deficit of the Trust.

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(9,463)	1,914
Non-cash income and expense:			
Depreciation and amortisation	6	6,139	5,029
Net impairments	7	5,506	-
Income recognised in respect of capital donations	4	(711)	(102)
(Increase) in receivables and other assets		(1,367)	(7,119)
(Increase) / decrease in inventories		14	(19)
Increase / (decrease) in payables and other liabilties		4,512	(433)
(Decrease) in provisions		(63)	(24)
Other movements in operating cash flows		-	(899)
Net cash generated from / (used in) operating activities		**4,567**	**(1,653)**
Cash flows from investing activities			
Interest received		69	28
Purchase of intangible assets		(7,656)	(9,483)
Purchase of property, plant, equipment		(21,043)	(11,386)
Sales of property, plant, equipment		158	16
Receipt of cash donations to purchase capital assets		500	-
Net cash used in investing activities		**(27,972)**	**(20,825)**
Cash flows from financing activities			
Public dividend capital received		3,310	6,571
Increase in loans from the Department of Health and Social Care	17	27,342	18,488
Repayment of loans from the Department of Health and Social Care	17	(2,933)	(507)
Increase in loans - other	17	623	2,501
Repayment of loans - other	17	(243)	(73)
Capital element of finance lease rental payments	17	(1,120)	(291)
Interest on loans		(1,384)	(847)
Interest paid on finance lease liabilities		(213)	(179)
PDC dividend (paid)		(1,071)	(936)
Net cash generated from financing activities		**24,311**	**24,727**
Increase in cash and cash equivalents		**906**	**2,249**
Cash and cash equivalents at 1 April - brought forward		**3,601**	**1,352**
Cash and cash equivalents at 31 March	15	**4,507**	**3,601**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 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.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust is in deficit because its costs exceed income. The deficit in 2018/19 is £11.6 million after accounting for a (£5.5 million) impairment, £7.0 million Provider Sustainability Funding (PSF) and adjusting for the £0.4 million net effect of donations. This gives an unadjusted deficit of £13.5 million, which was £0.3 million better than the Trusts pre PSF control total of £13.8 million.

During 2018/19 the Trust borrowed £27.3 million from the Department of Health (DH). £12.5 million of this was for capital investment and £14.8 million for revenue support. In addition the Trust has borrowed £0.6 million from Siemens for the Catheterisation Laboratory Project. £4.7 million associated with finance lease borrowing has also been recognised in the accounts. It is probable that the Trust will require further borrowing in the next year.

The Trust plans to break-even in 2019/20. This will be made possible by the receipt of net additional revenue funding totalling £12.5 million (additional funding provided to acute providers to recognise historic underfunding) and a £8.9 million cost improvement programme.

The Trust's 2018/19 deficit position is a concern but is not unusual in the NHS acute sector currently and does not represent a material uncertainty in relation to the Trust being a going concern. All liabilities are ultimately underwritten by DHSC as confirmed by statute therefore these accounts are prepared on a going concern basis.

Note 1.2 Critical judgements in applying accounting policies

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

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

Specifically the material estimates in the 2018/19 accounts include:

- recoverable deposits on community equipment. The Trust pays a deposit to an external company for equipment issues to patients in the community. If the equipment is returned and the company is able to re-use it the deposit is returned. Based on experience in 2018/19 it is assumed that 70.81% of deposits outstanding at the balance sheet date will be recovered which equates to £7.9 million.
- the Trust employs a professional valuer to value all land and buildings and estimate their useful economic lives which are used to calculate depreciation. Assets are revalued by the valuer as a minimum every five years. There has been a full valuation in 2018/19. The value of these assets at 31 March 2019 is £88.3 million.

Note 1.3 Interests in other entities

The Trust has a 25% share in Collaborative Procurement Partnership limited liability partnership (LLP) with three other NHS organsitaions. The LLP was established in 2017/18 and the investment in this is not yet material to the Trust and therefore assets have not been reflected in the accounts. £359k accrued income has been recognised in 2018/19.

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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not generally considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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

Note 1.5 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.
Employer's pension cost contributions are charged to operating expenses as and when they become due.
Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation:
- Property: valued as a specialised property; assets are valued at current value in existing in use. In practice this means many assets are valued at depreciated replacement cost;
- Plant and Equipment: depreciated historic cost;
- Land: fair value where available. If the Trust does not have access to the market because of statutory restrictions, land is valued at current value in existing use;
- Intangible Assets: fair value. If no market information is available, then depreciated replacement cost is used;

An item of property, plant and equipment which is surplus to requirements with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful 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. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the 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.

Note 1.7.3 Donated and grant funded assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.4 Useful 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
Land	-	n/a
Buildings, excluding dwellings	2	89
Dwellings	18	90
Plant & machinery	2	25
Transport equipment	7	7
Information technology	2	10
Furniture & fittings	5	8

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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 only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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.

Note 1.8.3 Useful economic life 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 - internally generated	4	20
Software - purchased	4	20

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 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.

Note 1.10.2 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.

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 as 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 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.

Note 1.10.3 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

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

Note 1.11.1 The trust as lessee

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

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

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

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

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

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

Note 1.11.2 The Trust as lessor

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

Note 1.12 Provisions

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

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 19 but is not recognised in the Trust's accounts.

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

Note 1.13 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
(i) donated assets (including lottery funded assets);
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility; and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.14 Value added tax

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

Note 1.15 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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

IFRS 14 - Regulatory Deferral Accounts

This applies to first time adopters of the IFRS after 1 January 2016. Therefore it is not applicable to NHS bodies.

IFRS 16 - Leases

Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Trust is party to 75 lease contracts as lessee of equipment with a historic cost of £4.4 million and another 210 contracts for lease cars. These are currently accounted for as operating leases under IAS 17 and so have not been recognised as an asset and corresponding liability on the balance sheet. This will change when IFRS 16 is implemented by DHSC bodies in April 2020 and the right to use many of the leased assets currently classified as operating leases will be included on the balance sheet as well as the associated borrowing.

The Trust is still assessing the impact of this change in accounting policy and plans to be ready for it's full implementation by April 2020. However, under IFRS 16 assets will be brought onto the balance sheet with a corresponding liability under borrowing with annual rental costs split between capital repayments and interest, so it is thought that the overall financial impact on the Trust will not be significant.

IFRS 17 Insurance Contracts

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

IFRIC 23 Uncertainty over Income Tax Treatments

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

Note 2 Operating Segments

The Trust reports to the Board, which is considered to be the Chief Operating Decision Maker, on a monthly basis the performance at a divisional level. In considering segments with a total income of 10% or more of the Trust's total income. The Trust has identified five reportable segments. The main source of income for the Trust is from commissioners in respect of healthcare services from CCGs who are under common control and classified as a single customer. Net assets are not reported to the Board on a segmental basis therefore have been excluded for the purposes of this note.

The Trust reports to the Board by directorate down to an operating contribution.

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2018/19	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	74,498	60,339	23,825	29,493	39,146	17,651	244,952
Expenditure	(62,598)	(51,062)	(16,418)	(28,166)	(37,653)	(58,518)	(254,415)
Contribution	**11,900**	**9,277**	**7,407**	**1,327**	**1,493**	**(40,867)**	**(9,463)**

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2017/18	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	67,870	57,981	23,859	34,204	53,241	15,705	252,860
Expenditure	(57,754)	(49,481)	(15,238)	(27,580)	(53,568)	(49,526)	(253,147)
Contribution	**10,116**	**8,500**	**8,621**	**6,624**	**(327)**	**(33,821)**	**(287)**

These segments represent the management structure in the organisation.

The commissioning arrangements for Suffolk Community Services altered with effect from 1 October 2017, with Ipswich and East Suffolk CCG paying Ipswich Hospital NHS Trust directly for some services, rather than all income passing through the Trust (as was the case from 1 October 2015 to 30 September 2017).

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

Note 3 Operating income from patient care activities

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)	2018/19 £000	Restated 2017/18 £000
Acute services		
Elective income	32,916	32,534
Non elective income *	63,739	61,631
First outpatient income	15,813	14,080
Follow up outpatient income	20,393	18,730
A & E income	9,092	8,546
High cost drugs income from commissioners (excluding pass-through costs)	14,352	13,743
Other NHS clinical income *	11,700	14,281
Community services		
Community services income from CCGs and NHS England	26,805	43,914
Income from other sources (e.g. local authorities)	9,606	5,450
All services		
Private patient income	2,320	2,648
Agenda for Change pay award central funding	2,435	-
Other clinical income	552	437
Total income from activities	**209,723**	**215,994**

* Prior year comparatives included an income classification error and have been restated by the following amounts:

	£000
Non elective income *	5,935
Other NHS clinical income *	(5,935)

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	14,235	13,748
Clinical commissioning groups	180,575	193,665
Department of Health and Social Care	2,435	-
Other NHS providers	8,300	3,551
NHS other	-	46
Local authorities	1,306	1,899
Non-NHS: private patients	2,107	2,648
Non-NHS: overseas patients (chargeable to patient)	213	121
Injury cost recovery scheme	529	316
Non NHS: other	23	-
Total income from activities	**209,723**	**215,994**
Of which:		
Related to continuing operations	209,723	215,994

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19 £000	2017/18 £000
Income recognised this year	213	121
Cash payments received in-year	196	101
Amounts added to provision for impairment of receivables	34	20
Amounts written off in-year	17	28

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	510	508
Education and training (excluding notional apprenticeship levy income)	7,601	7,067
Non-patient care services to other bodies	14,140	14,535
Provider sustainability / sustainability and transformation fund income (PSF / STF)	7,014	9,568
Income in respect of employee benefits accounted on a gross basis	52	49
Other contract income	5,081	4,923
Other non-contract operating income		
Receipt of capital grants and donations	711	102
Rental revenue from operating leases	120	114
Total other operating income	**35,229**	**36,866**
Of which:		
Related to continuing operations	35,229	36,866

Other income includes £1.8m car parking (2017/18 £1.9m) and £1.7m catering income (2017/18 £1.6m).

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 license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19 £000	2017/18 £000
Income from services designated as commissioner requested services	209,723	215,994
Income from services not designated as commissioner requested services	35,229	36,866
Total	**244,952**	**252,860**

Note 6.1 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	232	17,682
Purchase of healthcare from non-NHS and non-DHSC bodies	1,126	-
Staff and executive directors costs	162,669	147,785
Remuneration of non-executive directors	114	114
Supplies and services - clinical (excluding drugs costs)	29,531	30,432
Supplies and services - general	3,064	3,475
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,140	20,761
Inventories written down	133	111
Consultancy costs	153	2,590
Establishment	2,866	3,539
Premises	4,816	4,522
Transport (including patient travel)	2,182	1,584
Depreciation on property, plant and equipment	4,486	3,759
Amortisation on intangible assets	1,653	1,270
Net impairments	5,506	-
Movement in credit loss allowance: contract receivables / contract assets *	49	
Movement in credit loss allowance: all other receivables and investments *	-	(699)
Audit fees payable to the external auditor:		
audit services- statutory audit	54	54
other auditor remuneration (external auditor only)	5	5
Internal audit costs	144	126
Clinical negligence	7,315	6,399
Legal fees	145	103
Insurance	170	163
Education and training	558	605
Rentals under operating leases	5,819	5,952
Car parking & security	263	315
Hospitality	26	22
Losses, ex gratia & special payments	42	11
Other services, eg external payroll	-	233
Other	154	33
Total	**254,415**	**250,946**
Of which:		
Related to continuing operations	254,415	250,946

The audit fees disclosed are gross of VAT. The net figures are £45k for the statutory audit and £4k for other external auditor remuneration.

All internal audit costs are non-staff related as the service is provided by an external firm.

*Following the application of IFRS 15 from 1 April 2018, the Trust's credit loss allowance relating to work performed under contracts with customers is shown separately as contract receivables. Credit loss allowance for all non-customer contract receivables are shown separately under 'all other receivables and investments'. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 7 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	4,184	-
Other	1,322	-
Total net impairments charged to operating surplus / deficit	**5,506**	**-**
Impairments charged to the revaluation reserve	264	-
Total net impairments	**5,770**	**-**

Impairments arose in 2018/19 as a result of the revaluation exercise carried out at the end of the year. They related to the following buildings:

	Impairment £000
Quince House (offices) and new residence buildings.	
Valued at depreciated replacement cost, these were recently completed assets. The impairment figure is the difference between the carrying cost of these assets (£9.4 million and £12.7 million respectively) and the valuers assessment of their value on 31/03/19 (£7.9 million and £10.0 million respectively).	4,184
Oak house	
This building was previously used for accommodation and is now used as office space. This change of use altered the basis of valuation from existing use value (valued by reference to rental value) to depreciated replacement cost which produces a lower valuation because it results in a reduction of service potential.	
The carrying value of this building was £2.5 million but it was revalued down to £0.9 million.	
Impairment charged to operating deficit	1,322
Impairment charged to the revaluation reserve	264
	1,586

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	131,472	119,784
Social security costs	12,984	11,832
Apprenticeship levy	635	579
Employer's contributions to NHS pensions	15,595	14,146
Pension cost - other	31	-
Termination benefits	-	53
Temporary staff (including agency)	5,188	4,905
Total staff costs	**165,905**	**151,299**
Of which		
Costs capitalised as part of assets	3,236	3,514

Remuneration of non-executive directors is excluded from this note and is disclosed separately in note 6.1.

Note 8.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £14k (£70k in 2017/18).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Where employees are ineligible to apply to the NHS Pension Scheme they are able to apply to the National Employment Savings Trust (NEST). NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. NEST Corporation, the Trustee that runs the NEST scheme, is a non-departmental public body. It's accountable to Parliament through the Department for Work and Pensions but is generally independent of Government in its day-to-day decisions. Being a public body means that there are no owners or shareholders. As a Trustee, the scheme is run in the interests of the members.

Note 10 Operating leases

Note 10.1 West Suffolk NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where West Suffolk NHS Foundation Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Operating lease expense		
Minimum lease payments	5,819	5,952
Total	**5,819**	**5,952**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	1,050	1,067
- later than one year and not later than five years;	1,465	1,608
- later than five years.	9	17
Total	**2,524**	**2,692**
Future minimum sublease payments to be received	-	-

The lease costs in this note include the properties on licence from NHS Property Services used for the delivery of community services. No leases have been signed for these properties so £0 has been included in future commitments.

Note 11 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**1,490**	**29,900**	**3,874**	**35,264**
Additions	-	11,771	-	**11,771**
Reclassifications	-	3,874	(3,874)	**-**
Valuation / gross cost at 31 March 2019	**1,490**	**45,545**	**-**	**47,035**
Amortisation at 1 April 2018 - brought forward	**-**	**11,412**	**-**	**11,412**
Provided during the year	62	1,591	-	**1,653**
Amortisation at 31 March 2019	**62**	**13,003**	**-**	**13,065**
Net book value at 31 March 2019	**1,428**	**32,542**	**-**	**33,970**
Net book value at 1 April 2018	**1,490**	**18,488**	**3,874**	**23,852**

Additions include £4.1 million internally generated information technology relating to the capitalisation of a finance lease for Cerner systems with a useful economic life of 20 years. At 31/03/2019 this had a remaining net book value of £4.0 million.

Note 11.1 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**-**	**22,014**	**3,739**	**25,753**
Additions	1,490	4,147	3,874	**9,511**
Reclassifications	-	3,739	(3,739)	**-**
Valuation / gross cost at 31 March 2018	**1,490**	**29,900**	**3,874**	**35,264**
Amortisation at 1 April 2017 - brought forward	**-**	**10,142**	**-**	**10,142**
Provided during the year	-	1,270	-	**1,270**
Amortisation at 31 March 2018	**-**	**11,412**	**-**	**11,412**
Net book value at 31 March 2018	**1,490**	**18,488**	**3,874**	**23,852**
Net book value at 1 April 2017	**-**	**11,872**	**3,739**	**15,611**

Note 12.1 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**6,850**	**69,554**	**3,415**	**8,871**	**14,898**	**4**	**6,405**	**135**	**110,132**
Additions	-	6,231	9,676	2,292	1,252	-	498	-	**19,949**
Impairments	-	(3,240)	(2,693)	-	-	-	-	-	**(5,933)**
Revaluations	872	(6,229)	(102)	-	-	-	-	-	**(5,459)**
Reclassifications	-	8,071	532	(8,755)	6	-	146	-	**-**
Disposals / derecognition	-	-	-	-	(354)	-	-	-	**(354)**
Valuation/gross cost at 31 March 2019	**7,722**	**74,387**	**10,828**	**2,408**	**15,802**	**4**	**7,049**	**135**	**118,335**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**2,325**	**92**	**-**	**9,215**	**4**	**4,226**	**100**	**15,962**
Provided during the year	-	2,576	92	-	1,302	-	507	9	**4,486**
Impairments	-	(163)	-	-	-	-	-	-	**(163)**
Revaluations	-	(4,683)	(184)	-	-	-	-	-	**(4,867)**
Disposals / derecognition	-	-	-	-	(306)	-	-	-	**(306)**
Accumulated depreciation at 31 March 2019	**-**	**55**	**-**	**-**	**10,211**	**4**	**4,733**	**109**	**15,112**
Net book value at 31 March 2019	**7,722**	**74,332**	**10,828**	**2,408**	**5,591**	**-**	**2,316**	**26**	**103,223**
Net book value at 1 April 2018	**6,850**	**67,229**	**3,323**	**8,871**	**5,683**	**-**	**2,179**	**35**	**94,170**

Additions include expenditure of £9.3 million on the completion of new on-site residence buildings and £3.7 million on an ambulatory assessment unit.

Reclassification of dwellings is shown net of a £3.0 million transfer from assets under construction and £2.5 million transfer to buildings excluding dwellings.

Note 12.2 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**6,670**	**50,634**	**3,144**	**10,642**	**15,348**	**4**	**4,409**	**135**	**90,986**
Additions	-	6,078	-	6,706	280	-	1,996	-	**15,060**
Revaluations	180	4,365	271	-	-	-	-	-	**4,816**
Reclassifications	-	8,477	-	(8,477)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(730)	-	-	-	**(730)**
Valuation/gross cost at 31 March 2018	**6,850**	**69,554**	**3,415**	**8,871**	**14,898**	**4**	**6,405**	**135**	**110,132**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**194**	**-**	**-**	**8,512**	**4**	**3,876**	**79**	**12,665**
Provided during the year	-	1,957	85	-	1,346	-	350	21	**3,759**
Revaluations	-	174	7	-	-	-	-	-	**181**
Disposals / derecognition	-	-	-	-	(643)	-	-	-	**(643)**
Accumulated depreciation at 31 March 2018	**-**	**2,325**	**92**	**-**	**9,215**	**4**	**4,226**	**100**	**15,962**
Net book value at 31 March 2018	**6,850**	**67,229**	**3,323**	**8,871**	**5,683**	**-**	**2,179**	**35**	**94,170**
Net book value at 1 April 2017	**6,670**	**50,440**	**3,144**	**10,642**	**6,836**	**-**	**533**	**56**	**78,321**

Note 12.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	7,722	70,330	10,828	2,408	1,565	-	1,766	-	**94,619**
Finance leased	-	444	-	-	3,284	-	486	-	**4,214**
Owned - donated	-	3,558	-	-	742	-	64	26	**4,390**
NBV total at 31 March 2019	**7,722**	**74,332**	**10,828**	**2,408**	**5,591**	**-**	**2,316**	**26**	**103,223**

Note 12.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	6,850	63,608	3,323	8,871	1,555	-	1,462	-	**85,669**
Finance leased	-	477	-	-	3,300	-	715	-	**4,492**
Owned - donated	-	3,144	-	-	828	-	2	35	**4,009**
NBV total at 31 March 2018	**6,850**	**67,229**	**3,323**	**8,871**	**5,683**	**-**	**2,179**	**35**	**94,170**

Note 13 Revaluations of property, plant and equipment

The properties comprising the West Suffolk NHS Foundation Trust estate were valued in full as at 31 March 2019 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standards (2017) the national standards and guidance set out in the UK supplement (November 2017), the International Valuation Standards, and IFRS as adapted and interpreted by the Financial Reporting Manual (FREM). The valuation of specialised property was primarily derived using the Depreciated Replacement Cost (DRC) method, other in-use properties reported on an Existing Use Value basis, and non-operational properties reported on a Market Value basis.

The DRC basis of valuation seeks to determine the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

Property, Plant and Equipment on the balance sheet has a carrying amount of £114.9 million. Within this, £85.2 million is considered to be specialised property. This includes the hospital site and residences.

The key assumptions that are most likely to affect the valuations are:

- **Cost data**: The valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher this would have an impact on the value of specialised properties recorded in the balance sheet of an increase of £3.5 million.

- **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 £3.2 million.

The valuer also reviewed the useful economic lives of the Trust buildings. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives by category of asset are detailed in note 1.7.

The impact of the revaluation exercise is as follows:

	2018/19	2017/18
	£000	£000
Land	872	180
Buildings	(1,464)	4,455
	(592)	**4,635**

Note 14.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	17,475	-
Trade receivables*	-	5,890
Capital receivables	-	745
Accrued income*	-	10,890
Allowance for impaired contract receivables / assets*	(216)	-
Allowance for other impaired receivables	-	(167)
Deposits and advances	2,815	1,953
Prepayments (non-PFI)	942	868
Interest receivable	-	5
PDC dividend receivable	127	13
VAT receivable	900	1,169
Corporation and other taxes receivable	76	47
Total current trade and other receivables	**22,119**	**21,413**
Non-current		
Deposits and advances	5,054	3,925
Total non-current trade and other receivables	**5,054**	**3,925**
Of which receivables from NHS and DHSC group bodies:		
Current	13,277	14,275
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 14.2 Exposure to credit risk

	31 March 2019 £000	31 March 2018 £000
Ageing of impaired financial assets		
90- 180 days	42	1,406
Over 180 days	174	124
Total	**216**	**1,530**

	31 March 2019 £000	31 March 2018 £000
Ageing of non-impaired financial assets past their due date		
0 - 30 days	3,749	3,147
30-60 Days	398	445
60-90 days	214	634
90- 180 days	664	1,160
Over 180 days	1,709	546
Total	**6,734**	**5,932**

£5.1 million of the non-impaired financial assets past their due date are owed by NHS organisations.

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.

	2018/19 £000	2017/18 £000
At 1 April	**3,601**	**1,352**
Net change in year	906	2,249
At 31 March	**4,507**	**3,601**
Broken down into:		
Cash at commercial banks and in hand	62	21
Cash with the Government Banking Service	4,445	3,580
Total cash and cash equivalents as in SoCF	**4,507**	**3,601**

Note 16 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	7,995	6,027
Capital payables	2,097	4,034
Accruals	12,470	10,809
Social security costs	1,938	1,751
Other taxes payable	1,532	1,385
Accrued interest on loans*	-	125
Other payables	2,309	2,004
Total current trade and other payables	**28,341**	**26,135**
Of which payables from NHS and DHSC group bodies:		
Current	5,755	3,444

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 17 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Scoial Care	10,319	2,084
Other loans	281	216
Obligations under finance leases (Note 18)	1,553	814
Total current borrowings	**12,153**	**3,114**
Non-current		
Loans from the Department of Health and Scoial Care	77,069	60,706
Other loans	2,527	2,212
Obligations under finance leases (Note 18)	5,360	2,473
Total non-current borrowings	**84,956**	**65,391**

Note 17.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Finance leases £000	Total £000
Carrying value at 1 April 2018	**62,790**	**2,428**	**3,287**	**68,505**
Cash movements:				
Financing cash flows - payments and receipts of principal	24,409	380	(1,120)	**23,669**
Financing cash flows - payments of interest	(1,289)	(95)	(213)	**(1,597)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	125	-	-	**125**
Additions	-	-	4,746	**4,746**
Application of effective interest rate	1,353	95	213	**1,661**
Carrying value at 31 March 2019	**87,388**	**2,808**	**6,913**	**97,109**

Note 18 Finance leases

Obligations under finance leases where West Suffolk NHS Foundation Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**6,913**	**3,287**
of which liabilities are due:		
- not later than one year;	1,553	814
- later than one year and not later than five years;	5,070	2,273
- later than five years.	290	200
Net lease liabilities	**6,913**	**3,287**

In 2018/19 the Trust entered into a seven year lease arrangement for Cerner applications and services with a capitalisable value of £4.1 million.

Reconciliation between minimum lease payments and their present value

	2019 £000	2018 £000
Mininum lease payments		
Within one year	2,147	1,387
Between one and two years	2,128	1,322
Between two and five years	6,864	5,124
More than five years	619	937
	11,758	8,770
Future finance lease capital	(3,438)	(4,163)
Finance charges allocated to future periods	(1,407)	(1,320)
Net lease liabilities	**6,913**	**3,287**

Note 19 Clinical negligence liabilities

At 31 March 2019, £88,659k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2018: £64,194k).

Note 20 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	1,618	11,991
Intangible assets	9,411	7,021
Total	**11,029**	**19,012**

Note 21 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	31 March 2019 £000	31 March 2018 £000
not later than 1 year	2,434	2,405
after 1 year and not later than 5 years	5,905	7,585
paid thereafter	273	661
Total	**8,612**	**10,651**

Note 22 Financial instruments

Note 22.1 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**
Trade and other receivables excluding non financial assets	25,344
Cash and cash equivalents at bank and in hand	4,507
Total at 31 March 2019	**29,851**

£13.1 million of the Trust's financial assets relate to income owed from other NHS organisations (2017/18: £14.3m).

Of the remaining balance at 31/03/19, £7.9 million relates to deposits recoverable when community equipment is returned based on the likely proportion that will be returned.

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

There are no individually material debts owed by non NHS organisations and the risk profile of the asset is assessed as low which is the same as in 2017/18.

	Loans and receivables
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**
Trade and other receivables excluding non financial assets	23,408
Cash and cash equivalents at bank and in hand	3,601
Total at 31 March 2018	**27,009**

Note 22.2 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost
	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Loans from the Department of Health and Social Care	87,388
Obligations under finance leases	6,913
Other borrowings	2,808
Trade and other payables excluding non financial liabilities	24,871
Provisions under contract	23
Total at 31 March 2019	**122,003**

Borrowing excluding finance leases is at a fixed rate and apart from £2.8 million from a commercial loan provider is from the Department of Health.

Within trade and other payables excluding non financial liabilities, £5.7 million relates to liabilities with other NHS organisations.

There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as 2017/18.

	Other financial liabilities
	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39	
Loans from the Department of Health and Social Care	62,790
Obligations under finance leases	3,287
Other borrowings	2,428
Trade and other payables excluding non financial liabilities	20,655
Provisions under contract	218
Total at 31 March 2018	**89,378**

Note 22.3 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 22.4 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	37,161	23,863
In more than one year but not more than two years	12,997	10,653
In more than two years but not more than five years	26,604	16,952
In more than five years	45,241	37,910
Total at 31 March 2019	**122,003**	**89,378**

Note 23 New standards

Note 23.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £125k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £598k.

Note 23.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of IFRS 15 has not had a material impact on the Trust.

Note 24 Related parties

	Receivables		Payables	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Norfolk Community Healthcare NHS Trust	36	22	96	85
Ipswich Hospital NHS Trust	-	573	-	430
Colchester Hospital University NHS Foundation Trust	-	222	-	571
East Suffolk and North Essex NHS Foundation Trust	646	-	1,464	-
NHS West Suffolk CCG	1,250	1,812	1,099	728
NHS Ipswich and East Suffolk CCG	283	128	45	196
NHS South Norfolk CCG	1,232	745	124	123
NHS Cambridgeshire and Peterborough CCG	-	121	183	8
Health Education England	-	714	62	-
NHS England	5,387	7,239	28	44
NHS Resolutions (formerly NHS Litigation Authority)	-	-	4	4
NHS Property Services	75	36	2,068	667
Department of Health and Social Care	-	3	3	-
Total	**8,909**	**11,615**	**5,176**	**2,856**

	Income		Expenditure	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Norfolk Community Healthcare NHS Trust	39	70	60	11,091
Ipswich Hospital NHS Trust	2,163	4,837	93	8,352
Colchester Hospital University NHS Foundation Trust	409	1,429	1,484	5,648
East Suffolk and North Essex NHS Foundation Trust	8,605	-	4,918	-
NHS West Suffolk CCG	145,394	126,453	91	181
NHS Ipswich And East Suffolk CCG	18,336	51,494	1	153
NHS South Norfolk CCG	14,682	15,188	-	-
NHS Cambridgeshire and Peterborough CCG	2,901	3,292	23	17
Health Education England	7,507	6,734	22	17
NHS England	20,768	23,273	103	5
NHS Resolutions (formerly NHS Litigation Authority)	0	0	7,482	6,554
NHS Property Services	103	105	2,412	2,774
Department of Health and Social Care	2,475	3	8	5
Total	**223,382**	**232,878**	**16,697**	**34,797**

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent £711k on behalf of the Trust on capital items plus a further £462k on revenue items (2017/18: £340k on capital items plus a further £450k on revenue items). At the year end the Charity owed the Trust £169k (2017/18 £108k).

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

Note 25 Events after the reporting date

There are no identified adjusting or non-adjusting events after the reporting date with a material impact on the financial reporting.

22. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 26 July 2019

Agenda item:	22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 July 2019			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	X

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 27 September 2019

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Appraisal report	✓		Written	Matrix	KR
"Putting you first award"	✓		Verbal	Matrix	JB
Quality and learning report Q1, including - quality priorities - learning from deaths - findings of review into the increase in complaints	✓		Written	Matrix	RP/NJ
Consultant appointment report	✓		Written	Matrix – by exception	JB
Annual reports for: - infection prevention - safeguarding - equality - R&D annual report	✓		Written	Matrix	RP / NJ
National patient survey report (*if issued*)	✓		Written	Matrix	RP
Education report - including undergraduate training (6-monthly)	✓		Written	Matrix	
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
West Suffolk Alliance report	✓		Written	Matrix	KV/HB
7 day service report	✓		Written	Matrix	HB
Strategic view on the use of the Newmarket site		✓	Written	Action	CB
Primary care vertical integration – key decision point		✓	Written	Action	KV
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	AE

Digital board report, including community IT update	✓		Written	Matrix	CB
Council of Governors report	✓		Written	Matrix	SC
Board Assurance Framework (BAF)		✓	Written	Matrix	RJ
Scrutiny Committee report, including networked pathology strategy		✓	Written	Matrix	GN
Board room etiquette and behaviour		✓	Written	Matrix	SC
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Meeting dates for 2020/21	✓		Written	Matrix	RJ
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:30 ITEMS FOR INFORMATION

23. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Alan Rose

24. Date of next meeting

To NOTE that the next meeting will be held on Friday, 27th September 2019 at 9:15 am in Quince House, West Suffolk Hospital

For Reference

Presented by Alan Rose

RESOLUTION TO MOVE TO CLOSED SESSION

25. The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Presented by Alan Rose