NHS
The Ipswich Hospital
NHS Trust

Ipswich Hospital

Annual Report and Accounts 2017/18

Our Passion, Your Care.

Welcome

Celebrating Our Team Ipswich Colleagues

For our design theme this year, we have chosen to feature colleagues who featured in our Team Ipswich Awards in February 2018.

Front cover photographs:

The Team Ipswich Awards 2018

Row 1

Dr Bamini Vhadwana, surgical registrar
Nominee: Trainee of the Year Award

Julie Harper, district nurse development lead
Nominee: Leader of the Year Award

Ernie Dawson, volunteer, hospital radio and events
Nominee: Supporter of the Year Award

Row 2

Dr Jack Gordon, junior doctor
Nominee: Trainee of the Year Award

Amanda Bennett, Community Education Hub clinical educator
Nominee: Leader of the Year Award

Lizzy Anderson, Oncology senior medical secretary
Nominee: Living the Values Colleague of the Year Award

Row 3

Sterilizing engineers – Estates
Nominee: Team of the Year Award

Sue Ramsey, specialist respiratory physiotherapist
Nominee: Leader of the Year Award

Dr Naveed Malek, Neurology consultant
Nominee: Living the Values Colleague of the Year Award

Thank you to...

- All the staff of The Ipswich Hospital NHS Trust
- All our volunteers
- All our patients and visitors
- Fundraisers throughout the community – individuals, families and organisations
- The Ipswich Hospital Band
- The Ipswich Hospital Community Choir
- Hospital Radio Ipswich
- The media, including Ipswich Star, East Anglian Daily Times, BBC Radio Suffolk, Heart, Town 102, BBC Look East, ITV Anglia
- Health colleagues in the east of England

This report was compiled by the hospital's Communication team, and designed and printed by our Design and Print Services team. Photography is by freelance photographers.

If you would like a short summary of this document, or the whole document translated into another language, please ask an English-speaking friend to contact us on 01473 704770.

Polish język polski

Jeśli chcieliby Państwo otrzymać krotkie podsumowanie niniejszego dokumentu lub cały dokument w innym języku, prosimy o skontaktowanie się z Nami przy pomocy osoby anglojęzycznej pod numerem telefonu 01473 704770.

Portuguese Português

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Chinese 中文

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Bengali বাংলা

যদি আপনি এই নথিপত্রের সংক্ষিপ্ত সার, বা সম্পূর্ণ নথিপত্রের অন্য কোন ভাষায় অনুবাদ চান, অনুগ্রহ করে একজন ইংরাজি-ভাষী বন্ধুকে আমাদের সঙ্গে ০১৪৭৩ ৭০৪৭৭০ নম্বরে যোগাযোগ করতে বলুন।

Kurdish ی.کورد

ئەگەر دەتانەوێت کورتەیەک یان هەموو نەم بەڵگەیەتان بە زمانێکی تر هەبێت، تکایە لە یەکێ لە هەواڵانی خۆتان کە بە زمانی ئینگلیزی قسە دەکات داوا بکەن بە ژمارە تەلەفۆنی 01473 704770پەیوەندیمان پێوە بکات.

Farsi ی.فارس

گر مایلید خلاصه ای کوتاه یا کل این سند را به زبان دیگری داشته باشید، لطفا از یکی از دوستان خود که به زبان نگلیسی صحبت می کند در خواست کنید با شماره 01473 704770با ما تماس بگیرد.

Contents

This Annual Report has been prepared in accordance with the requirements set out in the Department of Health Group Manual for Accounts 2017/2018.

The Quality Account 2017/18 is a companion document to this report and is available online at www.ipswichhospital.nhs.uk

Performance Report

Overview

Chair's foreword

David White
Chair

It has been a significant year for Ipswich Hospital NHS Trust.

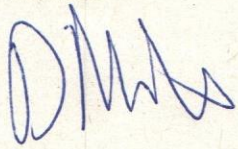
During 2017/18, our staff worked incredibly hard to maintain high standards of care for our patients, with those efforts rewarded in January when we retained our Care Quality Commission (CQC) rating of 'good'. As well as praising the dedication and kindness of our staff, the inspectors also highlighted several areas of outstanding practice. This included the care we provide to frail patients and the innovative techniques used within our children's service, such as animal handling to distract young patients who are anxious about their treatment. My personal thanks go to everyone who has worked so hard to continue delivering these high quality services while also looking for ways in which we can improve still further.

Our work to integrate health services to better meet the needs of patients continued this year, and in September we welcomed additional community-based healthcare staff to our organisation. This comes as part of a longer-term strategy for the NHS in Suffolk, which will see both acute hospitals work in partnership with GPs, the mental health trust and social care to join up services so that they better meet the needs of local people. Our vision is deliver more care outside of a hospital setting and closer to patients' homes, while also focusing more on preventative work so that people help themselves to stay well for longer.

The past year saw a raft of exciting developments at the Heath Road site. More of our wards were upgraded to the latest dementia-friendly standards, benefitting patients and their families as well as providing a better environment in which staff can work. We celebrated the first birthday of the Woolverstone Macmillan Cancer Centre, which has significantly improved the facilities from which our patients receive treatment. It was great to see work also starting on our new helipad to enable us to transfer patients to our ED more quickly. IHUG, the Ipswich Hospital User Group, continued to go from strength to strength and provide us with valued insight into the views of our patients. We also launched two charity appeals; the Blossom Appeal, which is raising money towards a £2.5 million Breast Care Centre, and the Children's Appeal, which aims to completely reconfigure our children's ward and outpatients department, making them lighter and brighter. Our sincerest thanks go to everyone who has, and continues to, give their time and talents to raise funds to support their local hospital – your efforts really do help make our patients' lives better every day.

The coming 12 months promises to be another significant year for Ipswich, not least as a result of our upcoming merger with Colchester Hospital. This merger provides us with a real opportunity to further improve the range and quality of services available to patients, offer the best treatments locally and attract even more of the best and brightest staff to East Anglia. Everyone working on this exciting project is focused on the benefits it will bring to our patients, and shares a commitment to keep them truly at the heart of our partnership moving forwards.

Once again, my thanks go to everyone who has worked so hard to care for and support patients this year. I look forward to continuing to work with our staff, volunteers, patients and the public as we continue to join up health services for the benefit of local people during the coming 12 months.



David White
Chair
29 May 2018

Overview

Chief Executive's overview

Every day, 3,500 people come to our hospitals and services for care.

Every day, hundreds of colleagues work incredibly hard to improve those 3,500 lives.

And every day, I am proud. When you multiply those daily figures by a week, a month, a year or a lifetime, the numbers are truly staggering.

With the 70th birthday of the NHS approaching this summer, there has been more discussion than ever on the future and sustainability of the NHS. Coupled with questions about our nation's identity post-Brexit, I'm reminded that the NHS is probably the greatest thing about this country, something we can all feel proud of together.

The question around the sustainability of the NHS is an important one. There is no doubt in my mind that with the significant challenges around finance and workforce, unless there is significant change, the NHS as we know it is under threat. As well as a long-term funding solution, we also need a long-term strategy for NHS and social care services. With the merger of Ipswich and Colchester hospitals we are starting to see how we can work together to sustain and develop our services.

It is also my privilege to lead the Sustainability Transformation Partnership (STP), which is a partnership of health and social care, statutory and third sector providers in Suffolk and north east Essex. The STP is starting to think about the health of our population as a whole rather than just the patient or local resident in front of us.

I am greatly encouraged by the quality of the debate within the partnership and the ambition which is developing.

This will be a year of fundamental change for us. The most significant driver for the organisation is how we can continue to provide high quality, safe and compassionate care to the 3,500 who need us every day.

Nick Hulme
Chief Executive
29 May 2018

Nick Hulme
Chief Executive

Overview

About The Ipswich Hospital NHS Trust

We are an organisation with a proud history and one that has long adapted and responded to changes in health needs and circumstances. Ipswich Hospital is recognised by our patients and peers as a provider of good quality healthcare with a reputation for delivering caring, compassionate services. Every day, over 3,000 patients rely on us to improve their lives. Our services include accident and emergency, critical care, planned medical and surgical care, consultant and midwifery-led maternity, neonatal and paediatric care as well as diagnostic and therapy services. Since October 2015, we have also taken responsibility for community hospitals in Felixstowe, Aldeburgh and at Bluebird Lodge in Ipswich, as well as for some community services. We also provide a range of specialised services including spinal surgery, radiotherapy, percutaneous coronary intervention and gynaecological cancer surgery to a wider catchment of more than 500,000 people.

The Trust has more than 550 beds in general acute, maternity, paediatric and neonatal services.

Across our 46-acre site, we employ just over 3,400 whole time equivalent NHS staff.

We have a catchment population of approximately 390,000 people, primarily drawn from the districts of Babergh, Mid Suffolk, Suffolk Coastal and Ipswich. We have a typically older catchment population than the UK average, with a greater proportion of the population aged over 55. The population is projected to increase by 3.7% by 2021. However, there is estimated to be an overall 13.6% increase in the catchment population of those 60 and older by 2021, and a 40% increase by 2037. Our catchment population has a longer life expectancy than that of England alongside a lower mortality rate in the main disease areas. This mortality rate is also decreasing over time, despite an increasing – and increasingly elderly – population. In contrast, the catchment population typically has a higher rate of disease prevalence than England. Combined with reduced mortality, this indicates an increased amount of co-morbidities, and people living for longer with poorer health.

Building on a solid foundation

Over the last three years we have:

- improved patient experience;
- reduced length of stay;
- improved quality of care by redirecting funding to invest in safer staffing;
- created a regional spinal centre;
- created a single point of access;
- built the Ipswich Heart Centre;
- partnered with Macmillan Cancer Support to build Woolverstone Day Unit;
- built a new drug centre for the manufacture of chemotherapy drugs; and
- redesigned central outpatient reception and waiting area.

We are also starting to change patient pathways to support people to live and be treated in the community. Over the next five years we will continue to evolve our organisation, responding to both internal and external changes, to become an outstanding provider of health services for our population.

Celebrating Our Team Ipswich Colleagues

Beth Thomas, community midwife
Nominee: Living the Values Colleague of the Year Award

Overview

About The Ipswich Hospital NHS Trust

Our plans in 2018/19

The Trust has developed a clear vision of where it wants to be over the next five years, which is consistent with the Suffolk and North East Essex Sustainability and Transformation Partnership (STP). This strategy, called 'Writing the Next Chapter', explains the steps we will take to deliver great care, be recognised as a leading innovator in healthcare nationally, further improve patient experience and become financially secure.

A key part of our work during the coming 12 months will be our merger with Colchester Hospital University NHS Foundation Trust. Due to take place in the summer, the merger will see a new trust created, called East Suffolk and North Essex NHS Foundation Trust. The aim of the merger is to make sure patients are seen at the right time while attracting and retaining the best staff and providing the latest treatments locally. The new organisation will be the largest NHS trust in the region, which will give us the scale to save, strengthen and grow some services. Both hospitals will continue to provide A&E, obstetric-led maternity and 24/7 emergency admissions.

The vast majority of outpatient appointments will continue to take place as they do now. However, we need to make sure patients only come to either hospital for an appointment if there is a clinical need for them to do so. We will look at how we use technology to reduce the number of times they need to attend, as well as reviewing how we could increase the use of telephone follow-up, for example. We will also be looking at how we use our community hospitals in Felixstowe, Harwich, Clacton, Halstead, Aldeburgh and Ipswich's Bluebird Lodge, as well as our community services.

Merging will also save patients journeys further afield to hospitals in London, Cambridge, Norfolk or Basildon, in turn ensuring they can get the high quality care they need closer to home.

Celebrating Our Team Ipswich Colleagues

Trauma and Orthopaedic Enhanced Recovery team
Winner: Team of the Year Award

Overview

Vision, goals and strategic objectives on a page

Vision	To be an outstanding provider of health services for our population			
Values	**Respect Kindness Listen & involve Professional Efficient Improving together**			
Success is…	✓ an 'Outstanding' CQC report; ✓ top 5% for the experience of care, and recommended by 97% of patients; ✓ top 10% for safety, as measured by the summary hospital-level mortality indicator; ✓ improve early detection and treatment for hypertension, atrial fibrillation, COPD and diabetes; ✓ constraining costs from 2017/18 to 2021/22, to support local STP financial recovery; and ✓ top 25% for staff satisfaction and engagement.			
Goals	**Deliver a great care experience**	**Be recognised as a leading innovator in healthcare nationally**	**Financially secure**	**Improve the experience of working in healthcare**
Strategic Objectives ***What we need to do***	• Work with others to deliver seamless, safe patient pathways across the system, supported by consistent communication. • Improve the environment that care is delivered in. • Ensure we deliver all care in accordance with our values.	• Embrace new ideas to deliver new, technology-enabled, financially viable ways of working. • Improve the health of our population and the use of self-care tools. • Increase provision of care in the community. • Push the boundaries through innovation and managed risk taking.	• Meet increasing demand without increasing resources. • Use resources more effectively to maximise efficiency of service models/ patient pathways.	• Engage and train staff to continue to deliver, and support the delivery of, care in a changing environment. • Proud of the care we provide. • Empower staff to take personal responsibility every day.
Primary Key Performance Indicators (KPIs)	• Provide increased community-based care to constrain emergency admissions to 2016/17 levels. • 25% reduction in the number of people dying in hospital.	• 60% reduction in outpatient follow-ups without a decline in outcomes. • All residential/ nursing homes to be supported by technology, training, education and collaboration.	• Top 10% for efficiency, as measured by Carter. • 13% reduction in agency expenditure from 2016/17 baseline.	• Top 25% for communication from management. • Top 25% for training and appraisal satisfaction.

Overview

Trust objectives

Key risks and mitigations

Risk	Likely to manifest as:	Risk management and mitigation
If we are unable to fill our staffing rotas then we will not meet patient needs consistently	• Potential for reduced quality and coordination of care • Negative impact on patient flow and access targets • Long-term impact on staff resilience and poor retention of staff	• Use of agency staff with resultant impact on financial plans • 3-month/12-week rosters prepared • Dedicated work to improve recruitment process and attractiveness as employer • Working across system to address workforce shortages and jointly manage impact
If system partners do not work optimally together then we will not deliver the best care for patients	• Organisational priorities are placed ahead of patients' needs • Sub-optimal pathways are developed and implemented • Too many patients are treated in the hospital and not in more appropriate places	• Alliance approach removes key organisational barriers • Engagement and relationship building with key partners • STP strategy sets shared principles agreed by all partners
If business planning risks are not adequately controlled then we may not be able to provide the level and scope of services currently offered to our local community	• Deterioration in contractual performance • Deterioration in quality of service provision	• Guaranteed income contract creates shared incentives • Devolved budgets and local delegation to clinical leaders supported by moderation and oversight • Supporting division to identify opportunities and mitigating actions • Delivery of sustainability and transformation programme
If staff do not have the required knowledge of the CQC fundamental standards for their role, there is a risk of patients receiving sub-optimal care	• Poor patient experience • Failure to meet regulatory obligations • Threat of regulatory sanctions	• Clear clinical leads identified for each area • Trust procedures reflect CQC standards where relevant • Staff CQC booklet provided on induction • Establish a clinical governance assurance framework • Continual dialogue with regulators as service changes are made

Continued on next page

Overview

Trust objectives

Key risks and mitigations (continued)

Risk	Likely to manifest as:	Risk management and mitigation
If we fail to recognise and manage suspected sepsis early then patient outcomes may be affected	• Poor outcomes for patients • Additional costs of treatment and length of stay	• Sepsis guidance and training for staff • Sepsis prompt section on drug charts • Updated policy to reflect latest NICE guidance • Explore business case for sepsis module on nerve centre
If site-wide redevelopment of the hospital estate does not occur then some parts of the estate may become unfit for purpose	• Parts of estate become unmanageable • Service users affected	• Backlog maintenance programme managed through Estate Strategy Board • Develop options for Bridge School and north end • Premises Assurance Model
If we do not have sufficient capacity with the appropriate skills and abilities in transformational management then we will not be able to realise our planned benefits	• Failure to deliver financial savings though cost reduction • Need to employ premium capacity resource to maintain access standards for patients • Implications for cash flow	• Streamlined programme management and planning processes • Capacity assessment undertaken • Sharing of redesign resources with commissioners • Use of temporary staff to focus on delivering sustainable change
If we do not plan for financial sustainability through transformation then we will not be able to provide the level and scope of services currently offered to our local community	• Deterioration in contractual performance • Inability to deliver Trust strategy • May lead to Trust being put into special measures by regulators	• Refresh of Trust strategy alongside STP to identify opportunities • System-wide work focussing on transformation • Internal transformation programme to improve efficiency of support services
If the Trust does not deliver the Cost Improvement Programme then we will fail to achieve financial objectives	• Increased Trust deficit • Cash shortfall	• Business planning cycle to identify CIPs • Accountability Framework to hold divisions to account or CIP delivery • Sustainability and Transformation Portfolio Board to oversee Trust-wide CIP delivery at programme level
If we are unable to secure cash support for our financial plan then we may not have sufficient cash to ensure payments are made in a timely manner	• Failure to meet access standards • Sub-optimal outcomes for patients • May not be able to sustain level and scope of service provision	• Extension of working capital facility • Cash management controls • Deliver STF fund trajectories

Overview

Quality

Approach to quality governance

The Director of Nursing and the Medical Director are joint executive leads for quality of care and clinical outcomes, supported by the Director of Governance, whilst recognising that everyone is responsible for quality. The Trust works on a risk and escalation basis for managing quality, and this has been built into our structures and processes.

Quality governance comes together through the Quality Committee, which is supported by:

- Sub-committees covering patient and staff safety; clinical effectiveness and patient and carer experience. These groups also oversee groups such as the mortality review group, and Divisional and Clinical Delivery Group level governance meetings which cover all aspects of quality.
- Dedicated audit days and clinical audit function.
- Schwartz rounds and after action reviews.
- Comprehensive SIRI investigations and reporting.
- Quality priorities reporting to Board through the integrated performance report.
- Quality metrics embedded into the Trust's Accountability Framework.
- Ward level capture and reporting on quality and safer staffing.
- Quality heat maps reviewed monthly by the Board.

Our measures of success for quality improvement agreed through our strategy, which was refreshed last year, are:

- Reduction in complaints regarding communication;
- Reduction in the number of people on end of life care dying in hospital;
- Reduction in unwarranted clinical variation, as measured by Carter;
- Reduction in delayed discharges of care;
- Minimise delay of clinical support services in patient pathways;
- Improvement in the Patient Led Assessment of the Care Environment review; and
- Improvement for patient recommendation scores.

Celebrating Our Team Ipswich Colleagues

Outpatient Parenteral Antibiotic Therapy team
Highly commended: Team of the Year Award

Overview

Quality

Quality priorities for 2017/18

Priority	Target	Key measures
To continue to develop services to support patients who are elderly and frail	• To achieve patients with a length of stay over 14 days, sustained at 105 patients. • To reduce the number of admissions required. • To expand service to become available seven days a week. • To further integrate with community services and social services.	• Monitor the number of patients referred to Frailty Assessment Base (FAB) and crisis action team (CAT) services, and of those seen, monitor how many patients subsequently avoided admission to hospital. • Monitor the length of stay of those patients who required admission following assessment by the FAB. • Emergency admission levels. • Patients in hospital over seven and 14 days. • % of patients discharged via pathway zero and pathway one via discharge to assess model. • Number of beds occupied in acute and community hospitals in accordance with detailed bed model.
To continue to improve our care to those at the end of their life and support patients who have limited treatment options	• To deliver high quality, compassionate and dignified end of life care for all patients. • Patients will receive the right care in the right place. • To increase the number of patients dying in the place of their choice.	• Monitor themes from complaints relating to end of life care. • Monitor results from DNACPR and national end of life audits to highlight themes for improvement. • Audit use of individualised care plans to ensure best possible practice. • Expand post bereavement follow up service with families.
To avoid delays in transfers of care of a patient from hospital or community beds to other care environments	• To reduce the number of patients who have to stay in hospital beyond the date when they are medically stable for discharge. This is a high priority 'system-wide' urgent care project. • To achieve and sustain delayed transfer of care (DToCs) rate of 3.5%. • Fully implement the system-wide discharge to assess model. • To achieve and sustain number of patients with a length of stay over 14 days at 105.	• Report DToCs. • Report readmission rates. • Report the number of patients in the hospital with length of stay over seven and 14 days. • Report the % emergency admission rate for patients over 75 years.
To continue to expand our dementia-friendly environment	• Increase the number of dementia-friendly wards in the hospitals managed by The Ipswich Hospital NHS Trust.	• Track progress of works to improve ward environments to ensure all work was completed within the agreed timescale. • Measure the number of incidents of violence and aggression in these areas. • Patient, carer and staff experience findings.
Work with all clinical partners to identify the most appropriate service for children and young people needing unplanned medical advice or care.	• Reduce the number of under 18s attending ED by 5% by 2022, against a growing population.	• Monitor the number of attendances in ED by children and young people.

Overview

Quality

Accountability

The Trust has an Accountability Framework (AF) in place which brings together a range of indicators at a divisional level. These are then grouped into the Care Quality Commission (CQC) quality domains and a financial score. Monthly meetings are held between the Divisions and the Executive to review performance. Escalation reports are also presented to the Board and relevant sub-committees. Each Division is given an oversight category based on their performance. These are:

- Special measures
- Rapid improvement
- Intervention
- Standard oversight
- High performer

The examples of intervention under special measures include one or more of the following:

- Financial – suspension of delegated authority;
- Financial – Director approval of all purchase orders;
- Loss of decision making powers;
- Divisional Board capability review by third party;
- Division Board to Trust Executive, special meeting(s);
- Improvement plan(s) to be approved and monitored by Trust Executive via the AF oversight meetings or other stated forum;
- Further reviews as needed;
- Any other intervention as determined by the Trust Executive taking into account the specific circumstances triggering this escalation.

Ward-level reports are also produced for safer staffing and quality heat map on a monthly basis, and these are reviewed by the Board.

Celebrating Our Team Ipswich Colleagues

Frailty Assessment Base and Crisis Action team
Nominee: Team of the Year Award

Overview

Activity

Activity planning

A failure to manage activity growth is the single biggest risk to the sustainability of the local health economy. Therefore the Trust has agreed key activity-based objectives which will be delivered with all partners across the health system:

- Create urgent and emergency care pathways which treat patients in the most appropriate place;
- Integrate elective and chronic care pathways so patients only come to hospital when they really need to and all our services are safe, secure and have a sustainable future; and
- Ensure there is appropriate capacity in the right place in the care system.

The Trust and CCG have built a contractual and activity framework based on the following principles:

- The Sustainability and Transformation Partnership (STP) provides a framework which ensures financial sustainability for the whole health system;
- Contained within this envelope is a realistic level of affordable growth – c2.5% overall per year; and
- The Trust is undertaking a bottom-up assessment of growth on a specialty-by-specialty level for the purpose of:
  - understanding the key areas of demand which put at risk being able to hold to the principles of the STP;
  - agreeing joint programmes of work with partners to manage down that risk; and
  - agreeing appropriate risk share agreements for managing unplanned changes in demand.

As system partners we all recognise that demand management schemes will be a key focus over the next five years, and already have plans in place to address this:

- Within the STP we are focussing on prevention, self-care and independence, and improved community care;
- A business case has been prepared for an urgent care centre on the Ipswich Hospital site which will handle all walk-in activity; and

Within our elective areas we have also developed:

- Revised and integrated pathways for musculoskeletal conditions including a single point of access;
- Pre-referral guidance for GPs in a range of specialties – this provides initial treatment plans to attempt before referring, highlights alterative pathways, and ensures an appropriate history is taken with all relevant tests so the patient can be diagnosed at their first attendance; and
- Rapid screening clinics in dermatology – the consultant purely focuses on the diagnosis and can see significantly more patients in a clinic with appropriate support from other clinical staff to start the treatment of the patient.

Overview

Activity

A demand management rollout programme has been agreed by the STP which covers:

- general medicine;
- geriatrics;
- phase 2 MSK (T&O, pain, rheumatology);
- cardiology;
- stroke;
- gastroenterology including endoscopy; plus a further phase covering general surgery, vascular, breast, ENT,
- dermatology and A&E.

The Trust has placed an intensive focus on recovering our A&E performance. A range of initiatives have been implemented across the department, including listening events and electronic records. However, flow through the hospital remains the main issue with delayed transfers being the key bottleneck.

Celebrating Our Team Ipswich Colleagues

Danielle Evans, student nurse
Nominee: Trainee of the Year Award

Overview

Activity

Aside from delivering key operational standards the Trust has set itself the following measures of success for activity and demand management. These are currently in draft form as we complete our strategy consultation:

Metric	Explanation of assumption	2018/19	2019/20	2020/21	2021/22	Total
Emergency Admissions	% reduction each year	5%	5%	5%	5%	0%
Outpatient Follow-ups	% reduction each year	15%	15%	15%	0%	52%
Excess Length of Stay (elective)	% of cost of LOS reduced each year	10%	10%	10%	10%	45%
Delayed Transfers of Care	% of cost of DToC reduced each year	20%	20%	20%	20%	74%
Re-admissions	% of cost of readmissions reduced each year	20%	20%	20%	20%	74%

Performance analysis

Performance against key indicators

Celebrating Our Team Ipswich Colleagues

Dr Nick Schindler, paediatric registrar
Highly commended: Trainee of the Year Award

The Trust maintained a strong performance across a range of targets, national standards and other key performance indicators.

Key facts and figures

Births:
3,586

Emergency Department attendances:
86,757

Planned admissions:
6,976 excluding day cases
53,062 including day cases

Unplanned admissions:
41,464 including maternity
33,660 excluding maternity

Outpatient attendances:
755,757

Number of appointments people did not attend:
37,544

Diagnostic Imaging examinations (2017 calendar):
248,311

Referrals from GPs and dentists:
95,374

Performance analysis

Performance against key indicators

Key performance indicators (KPIs)

Indicator	Subsections	Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4
From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	NO	NO	NO	NO
All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	YES	YES	YES	NO
	Drugs	98%	YES	YES	YES	YES
	Radiotherapy	94%	YES	NO	NO	YES
All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	NO	NO	NO	NO
	From NHS Cancer Screening Service referral	90%	YES	NO	NO	NO
All cancers: 31-day wait from diagnosis to first treatment		96%	NO	YES	YES	YES
Cancer: Two-week wait from referral to date first seen, comprising:	All urgent referrals	93%	YES	YES	YES	YES
	For symptomatic breast patients (cancer not initially suspected)	93%	NO	YES	YES	NO
A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	NO	NO	NO	NO
Clostridium difficile	Is the Trust below the YTD ceiling?	12	YES	NO	NO	NO
MRSA	Is the Trust below the YTD ceiling?	0	NO	NO	NO	NO

Performance analysis

Operating financial review

In 2017/18, the Trust returned a deficit of £13.4m. This is the financial performance against which the organisation is measured, as it excludes non-recurrent costs associated with impairment of assets and non-recurrent grants and charitable fund income net of depreciation. The operating deficit recognising the above was actually £12.1m. The Trust ended the year £4.7m ahead of the planned deficit of £18.1m.

Continuing improvements to financial management across the organisation helped to identify and deliver £15m of cost improvement efficiencies in-year, while £10.2m of these efficiencies are recurrent into future years. The primary aim of these programmes is to deliver sustainable improvements in operational and financial performance across the Trust. Key successes in sustainable improvement during 2017/18 include improved pathways to make better use of resources, reduced reliance on temporary staffing and better procurement. A use of resources review during the year identified areas for the Trust to focus on to further improve effectiveness and efficiency.

Total income rose by £25.2m (8.5%) in 2017/18 as a result of increased activity across the year, £11m in sustainability and transformation support and the commencement of the new community services contract. Total operating expenses increased by £15.3m. The Trust continued with the 'guaranteed income contract' with our lead commissioner, an approach which is helping to underpin the system's financial position and focus all organisations on the system-wide costs of providing healthcare.

Total pay increased by £10.6m (6%) through national pay awards, increases in activity as well as the full-year effect of the increased community services contract introduced in October 2017. The Trust reduced total expenditure on agency staffing from £11m in 2016/17 to £9.9m in 2017/18.

Non-pay operating expenditure, excluding impairments, was £12.9m higher (10% year-on-year) in 2017/18 with the cost of the community contract and general increases in volume of care the primary drivers of this increase. As with the majority of Trusts, contributions to the national clinical negligence scheme increased by £1.2m for the Trust.

Whilst the financial plan for 2017/18 was delivered, as a consequence of the operating deficit, the Trust was required to secure loans to underpin cash management in-year, with the total borrowing standing at £68.8m. Cashflow is closely aligned to the underlying financial position of the organisation and will remain as such for the medium-term. The financial position impacted on the 30-day performance of the Trust in 2017/18, with careful management of scarce cash resources remaining a priority all year. Small and medium enterprises are prioritised; the Trust Executive maintains close scrutiny of this

Celebrating Our Team Ipswich Colleagues

Suja Varughese, Debenham ward sister
Highly commended: Leader of the Year Award

Performance analysis

Operating financial review

via the Finance and Performance Committee.

The Trust invested £12.7m in maintaining and developing the asset base during 2017/18, including:

- £0.5m on the GP streaming service;
- £0.9m on Brantham Ward refurbishment;
- £0.4m on the refurbishment of dementia wards; this vital work was funded through the Peter Gibbons legacy which the Trust received in 2015/16;
- £3.6m replacing and upgrading medical equipment across the Trust;
- £1.2m backlog maintenance across the Trust;
- £1.9m on enhancing the IT infrastructure;
- £1.7m general site improvements.

The financial outlook for the Trust remains very challenging into 2018/19 and beyond. The deficit of £13.4m in the past year was delivered with £11m non-recurrent sustainability and transformation funding (STF). The plan for 2018/19 is a deficit of £15.3m, after assuming receipt of £7.5m STF for a further year. The Trust Board has reviewed the financial projection for 2018/19 and believes it to be a credible and appropriate plan, whilst recognising that there is an increased risk profile to the plan linked to a challenging requirement to identify and deliver significant efficiencies. In March 2018, the Trust Board approved a move to full business case for a merger with Colchester Hospital University NHS Foundation Trust in the early part of 2018/19.

Celebrating Our Team Ipswich Colleagues

Care Coordination Centre team
Nominee: Team of the Year Award

Performance analysis

Our buildings and structure

Once again this year, the estates and facilities capital development team have delivered a number of critically important projects across the hospital site. They include:

Brantham Ward and assessment area

The 20-bedded Brantham Ward and neighbouring assessment area underwent an extensive refurbishment and redesign to improve its facilities, patient flow and access and make sure it meets the highest dementia-friendly standards.

Pictorial signs and colour-coded walls were introduced to help patients find their way, while bed areas have been decluttered, bathrooms and lighting improved and calming artwork added. In addition, a four-bedded observation bay has been created, complete with cardiac monitors, as well as a private side room so that staff can provide dedicated care to patients at the end of their lives.

A psychiatric assessment room has also been added, along with an informal quiet room to give patients who have recently received a diagnosis a comfortable space to ask questions and spend time with their families.

Improvements have also taken place in the Brantham Assessment Area, where patients undergo tests before a decision is taken on whether to admit or discharge them. Access from the Emergency Department has been improved to increase patient flow through the unit, while an improved ambulatory care area has also been created for patients who do not need a bed and are able to receive treatment in a chair.

SPECT –CT camera in Nuclear Medicine

More of our patients can now have their diagnosis confirmed during a single visit following a £958,000 project to install a state-of-the-art scanner which takes two types of image at once.

The SPECT-CT camera automatically fuses together a nuclear medicine scan and a CT (computed tomography) scan, giving clinicians a much clearer image to help diagnosis and treatment planning. Previously, patients who needed both scans would have had to visit the hospital twice.

The new camera runs alongside the hospital's existing gamma camera, and replaces an older machine which was only able to take limited nuclear medicine images.

As part of the installation, the Nuclear Medicine department has been given a facelift. The reception is now lighter and more open with better disabled access.

Sky lights in Radiotherapy

The sky is the limit in our Radiotherapy waiting room thanks to new sky light ceiling panels, which have been added to make the wait a little lighter and brighter for patients who regularly return to the department for treatment.

New hospital helipad

A new lifesaving helipad has been created next to our Emergency Department after The HELP Appeal, the only charity in the country dedicated to paying for the construction of hospital helipads, agreed to fund the entire £250,000 project.

The new helipad will make it much faster to transfer seriously ill patients in the hospital, giving them the best possible chance of survival and recovery. It also means our Trust and air ambulance teams can transfer patients from Ipswich Hospital for emergency treatment

Celebrating Our Team Ipswich Colleagues

Pam Talman, Patient Experience coordinator
Highly commended: Living the Values Colleague of the Year Award

Performance analysis

Our buildings and structure

in other specialist centres quickly and smoothly.

The illuminated helipad is one of just a handful that can receive night flights, which means air ambulance teams are now able to bring critically injured patients to Ipswich Hospital around the clock rather than to hospitals further afield.

Previously, it took around 15 minutes to transfer critically ill patients from the old helipad, at the back of Copleston High School's field, into the ED.

Car park 'U'

By creating a new temporary car parking area for staff next to the new helipad and reconfiguring other staff car parks, the Trust has created an additional 80 spaces for patients and visitors. In addition, new car park ticket machines have been installed in most patient car parks, with the ability to use debit/credit card payments rather than cash only.

Lift refurbishments

As part of our ongoing lift refurbishment scheme, we have refurbished the lifts within our oncology building to provide patients, visitors and staff with a smoother, quicker ride. The lifts are also Disability Discrimination Act compliant, and brighter and more modern.

GP streaming

The GP steaming service opened its doors in 2017 to ensure ambulatory patients presenting for emergency and urgent care are provided with the right care, by the right professional at the right time. The service aims to:

- Release capacity for ED clinicians to treat people with trauma or who are medically unstable/acutely ill.
- Educate patients that their needs do not require the services of the ED, and who to seek help from in future.
- Encourage people to register with a GP and access general practice services.
- Minimise the amount of time spent waiting for an assessment and treatment in ED.

This scheme was part of a comprehensive programme of development work which took place during the year to address the increasing demand for ED and urgent care services.

Creating a dementia-friendly environment on Stradbroke Ward

Following on from the improvements to Washbrook and Woodbridge Wards in 2016, the Trust completed its third dementia-friendly refurbishment from the generous legacy left to the hospital by Peter Gibbons. Taking place during the summer, the refurbishment saw the environment improved, and clear, open sharing spaces created, while enhanced navigation aids have been added to help patients to find their way around.

Celebrating Our Team Ipswich Colleagues

Judy Smith, volunteer for the Trust's Readers Panel

Nominee: Supporter of the Year Award

Performance analysis

Our buildings and structure

Sustainability

Leadership and engagement

The Trust recognises the impact of its operations on the local and global environment and is committed to demonstrating leadership in sustainable development.

We have achieved some major successes in carbon-saving measures in our buildings, in particular the recent addition of the biofuel CHP unit at the end of 2016/17. The Trust is now in a unique position where the majority of both its heating and electricity is produced on-site from renewable sources, and means we are on track to meet our 28% CO_2e reductions for 2020.

However, we recognise that there is a need to bring our overall sustainability agenda up to date and reflect the new partnership with Colchester Hospital University NHS Foundation Trust. The Trust appointed a new Energy and Sustainability manager in November 2017 to drive the sustainability agenda forward.

Our Sustainable Development Management Plan (SDMP) was revised in 2017 and will be adapted to suit the new East Suffolk and North Essex NHS Foundation Trust in 2018/19. We are also anticipating that the sustainable development assessment tool and climate change adaptation planning will also be completed once the merger with Colchester has taken place in order to align both organisations into a joint vision.

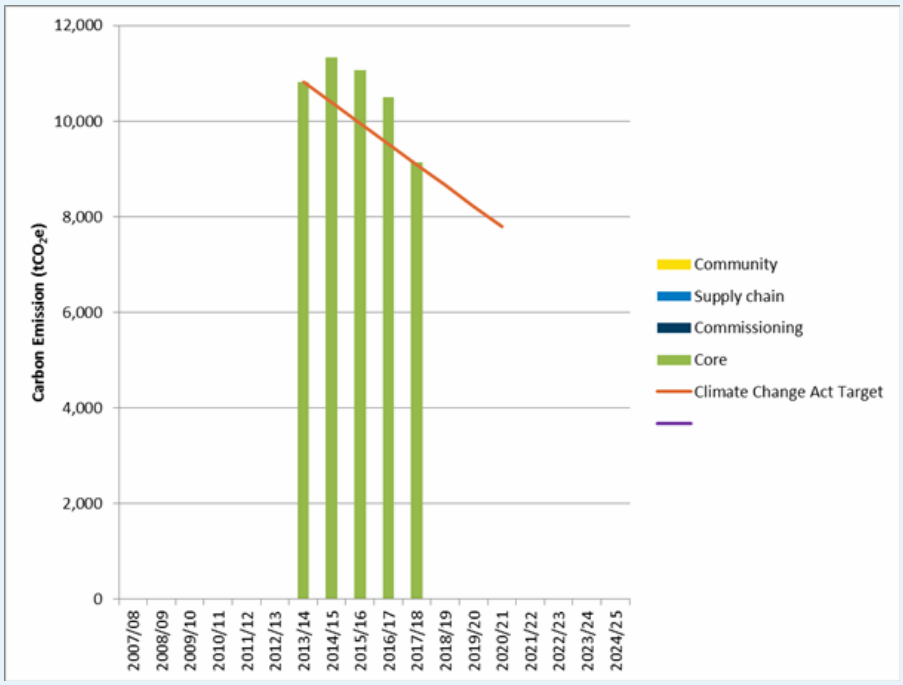
In March 2018, we took part in NHS Sustainability Day by engaging with the new hotel services provider (OCS) and Suffolk County Council to promote and engage with staff, public and visitors to the hospital.

Resources

Energy and water

Energy consumption decreased significantly in 2017/18, putting the Trust fully on track to meet the 2020 target. We anticipate a significant increase in biofuel usage for 2018/19 which will further reduce the CO_2e emissions.

Water consumption has also decreased, which is a reverse of the previous two years.



Water		2014/15	2015/16	2016/17	2017/18
Mains Water	m^3	136,205	154,459	160,834	139,599
	tCO_2e	124	141	146	127

Performance analysis

Our buildings and structure

Renewable energy – biofuel

In April 2017 the new on-site biofuel CHP unit was brought online. This innovative scheme burns used cooking oil (which would otherwise go to waste) to generate renewable electricity for use by the hospital. Although a number of restrictions have impacted on the full utilisation of the plant, we are assured by its performance to date.

A significant increase in utilisation is anticipated for 2018/19 which will further reduce our carbon emissions and energy costs from 2018/19 onward.

Renewable energy – waste

100% of our clinical waste is incinerated on-site and the heat recovered is used to heat the hospital, meaning much less gas is used than at other equivalent hospitals. This reduces our carbon emissions by more than 1,100 tonnes.

Travel

Following on from the updated Travel Plan, we have engaged with lift share providers, retendered for the parking administration and monitoring provider, as well as liaising with the local council to publicise and promote sustainable travel options. We are planning to carry out an in-depth analysis of staff parking during 2018/19 so that we can identify more opportunities for sustainable travel.

We have invested in additional staff parking which has also increased the availability of patient spaces. This initiative reduces stress and the associated carbon emissions though users struggling to find spaces and improves our corporate responsibility to our neighbours by reducing parking on local streets.

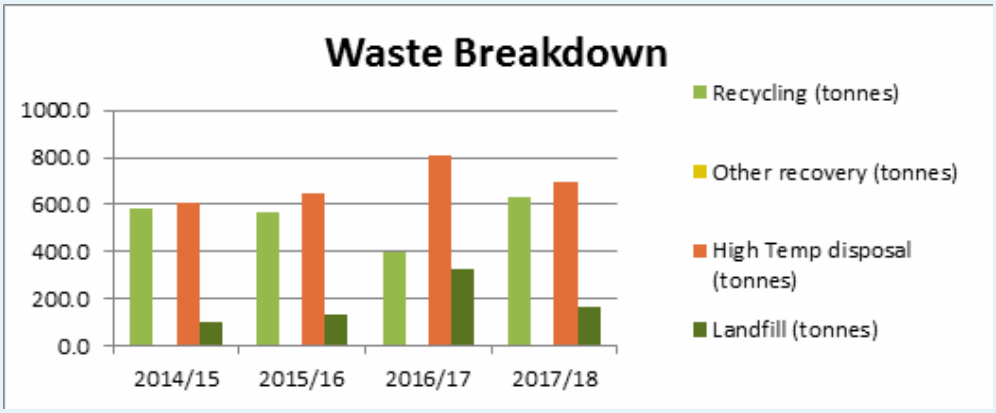
Procurement

The Estates and Facilities department worked closely with its hotel services partners on a number of sustainability initiatives as part of the retendering process in 2017/18. During the new contract with OCS, we will make progress in the following areas for 2018/19:

- On-demand food ordering system, which means patients will be able to order meals up to an hour before meal times which will avoid wasted meals.
- Staff will have the ability to order and pay for meals online so that they can collect meals faster and increase the amount of time they spend resting, in turn improving wellbeing.
- Increased offering of out-of-hours food, which again improves the wellbeing of our staff and visitors.
- Increased parking staff to help patients and staff with parking and travel.

Waste

Our total waste production decreased by 3% in 2017/18, whilst recycling has increased significantly. The Trust now sends 42% of its waste for recycling and 47% for incineration, which is subsequently used to produce steam and hot water. The remaining 11% goes to landfill.



Performance analysis

Our buildings and structure

Fire safety

Throughout this year, fire safety has again played a significant role in the work plans within not only the estates department but also the wider hospital. The tragic events at the Grenfell Tower brought into sharp focus the need to remain vigilant and proactive in relation to fire safety. Ipswich Hospital's site does include the tower block which houses our maternity department, and following Grenfell we undertook additional investigations, checks and works on the block to assure ourselves of its safety in relation to fire. The block itself does not contain the cladding suspected of being the main cause of fire spread at Grenfell.

In addition, we have undertaken intrusive surveying of all floors to assure ourselves of the condition of our compartmentation and have completed works to resolve any high risk breaks in our compartmentation. We have also reviewed our evacuation plans and ensured that they can be carried out.

We have worked in conjunction with our recently appointed authorising engineer for fire, who is external to the organisation and provides challenge and assurance in relation to our fire management plans and strategy. In addition to this, Suffolk Fire and Rescue Service has visited the hospital to deliver a training course in relation to the fire safety requirements for healthcare premises, which has further strengthened our relationship with the service.

Security

In the past year we have continued with our upgrade of the CCTV recording system by adding new high definition cameras and improving our monitoring abilities. We have supported our colleagues from Suffolk Constabulary on numerous occasions, including providing vital CCTV evidence to support criminal investigations and prosecutions. In conjunction with Suffolk Police, we also hosted a successful 'white ribbon' awareness week to raise awareness of domestic violence.

We have revised the training we provide in relation to conflict resolution and breakaway techniques. These changes have been welcomed by staff and feedback on these sessions has been overwhelmingly positive, while the training has raised awareness of security incidents and the need to report incidents of violence and abuse.

The total number of assaults on staff were 111 of a physical nature and 45 of a verbal abusive nature. Where appropriate, these incidents were reported to the police and the appropriate action was taken which, in some cases, resulted in convictions against individuals. It may not be appropriate to take specific police action if there are mitigating circumstances, for example where a patient's behaviour is as a result of a medical condition or as a result of medication prescribed to them. In these situations, we support staff members in finding alternative safer ways to treat patients in order to mitigate the risk of repeat assaults.

The increase in security awareness has led to a reduction in reports of thefts across the Trust from 35 in 2016 to 15 last year. We have established a security management group which meets regularly to oversee the security workstreams and has a multidisciplinary attendance list to ensure the correct level of scrutiny and involvement is in place.

Emergency planning

During the year we carried out a self-assessment in relation to the NHS Core Standards of Emergency Planning Resilience and Response. Our duties as a category one responder under the Civil Contingencies Act 2004 fell from 'fully compliant' to 'substantially compliant'. Although the cause of the reduction is largely due to a change in the scoring criteria, there were elements of our management of emergency planning which required addressing.

This year we have appointed a Non-Executive Director to ensure there is challenge and scrutiny of our emergency planning activities. The accountable director chairs the emergency planning group, which oversees the work plans in relation to all emergency planning activities including those actions related to the self-assessment.

Along with our health, social care, police, fire, ambulance, council, environmental, military (both UK and US) and Public Health England partners, we have reviewed, designed and tested resilience plans. We have strengthened our ties with Colchester Hospital in sharing an emergency planning lead across two sites and plan

Performance analysis

Our buildings and structure

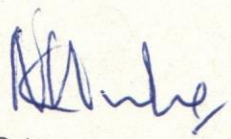
in the coming year to build succession planning into the role by developing internal talents.

Before the winter began, we carried out a local table-top exercise to review our plans in the event of a flu epidemic and reviewed our pandemic flu plans which proved useful in the recent winter pressures. Emergency department and operation centre representatives also attended the East of England Ambulance Service mass casualty role play exercise in October to gain experience of patient treatment prior to hospital admission. This experience has helped our teams in planning for the handover of patients in such an event.

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:



Date:
29 May 2018

Celebrating Our Team Ipswich Colleagues

Medicines Information team – Pharmacy
Nominee: Team of the Year Award

Accountability Report

Corporate governance report

Directors' report

Composition of the Board

The overall management of the hospital is the responsibility of the Trust Board which comprises a Chair, five Non-Executive and five Executive Directors. The Trust also has one Associate Non-Executive Director. All Non-Executive Director appointments are made through the NHS Trust Development Authority, which joined with Monitor on 1 April 2016 to become NHS Improvement.

The Chair and all Non-Executive Directors are members of the Trust Board and Remuneration Committee. The Remuneration Committee is attended by the Chief Executive and the HR Director as expert advisors to the committee.

Membership of the Audit Committee comprises three Non-Executives. The Chief Executive and Director of Finance and Performance usually attend each meeting as well as external and internal auditors. The Committee meets six times a year. The role of the Audit Committee is to ensure effective control programmes are in place and provide an independent check upon the Executive arm of the Board.

Chair and Non-Executives – at 31 March 2018	
David White	Chair
Tony Thompson	Non-Executive Director
Andrew George	Non-Executive Director
Laurence Collins	Non-Executive Director
Helen Taylor	Non-Executive Director
Richard Kearton	Non-Executive Director
Elaine Noske	Associate Non-Executive Director

The Audit Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes. In particular, the committee's work focuses on the framework of risk control and related assurances that underpin the delivery of Trust's objectives. The Audit Committee receives and considers reports from both internal and external auditors and reviews the annual accounts and financial statements. Through this committee, actions are put in place to ensure that all recommendations of internal and external audit reports are considered, as well as other assurance functions.

The Chief Executive and Executive Directors were appointed using open competition and a selection process. They were appointed on a permanent basis. All are subject to annual performance reviews and all usual Trust policies and procedures. Other assurance committees of the Board are Finance and Performance, Quality, Workforce, Remuneration and Terms of Service and Charitable Funds. Details of Directors' remuneration are given on page 54 of this report.

Corporate governance report

Directors' report

Composition of the management Board

We place clinicians at the centre of the hospital's leadership. There are three operation divisions each led by a Divisional Clinical Director supported by a Head of Nursing, Head of Operations and an HR and Finance Business Partner. Clinical delivery groups support the Board of each division and represent all areas within the division. Corporate services provide support to all of the operational areas.

The Executive Directors work closely with the divisional leadership in developing strategic and operational plans. A Trust-wide leadership group called the Executive Management Committee contributes to and implements Board, Executive and clinical team decisions.

Trust Executive Directors – at 31 March 2018	
Nick Hulme	Chief Executive
Neill Moloney	Managing Director
Dr Crawford Jamieson	Medical Director
Lisa Nobes	Director of Nursing
Simon Rudkins	Acting Director of Finance and Performance
Clare Edmondson*	Director of Human Resources
Denver Greenhalgh*	Director of Governance
Ali Bailey*	Director of Communications
Simon Hallion*	Director of Operations
Paul Fenton*	Director of Estates and Facilities
Mike Meers*	Director of Information Communications and Technology
Alison Smith*	Director of Community Services

** Non-voting Board members*

Celebrating Our Team Ipswich Colleagues

Biochemistry
Nominee: Team of the Year Award

Corporate governance report

Directors' report

Declaration of interests 1 April 2017 to 31 March 2018	
Ann Alderton Company Secretary	• Company Secretary – Colchester Hospital Foundation Trust • Husband is manager at West Suffolk Hospital NHS Trust • Shareholder and Managing Director – Tredaran Consulting Ltd
Ali Bailey Director of Communications (From 01 May 2017)	• Nil
Laurence Collins Non-Executive Director	• Governor – Rushmere Hall Primary School, Ipswich • Member of Two Rivers Medical Centre PPG
Clare Edmondson Director of Human Resources	• Nil
Paul Fenton Director of Estates and Facilities	• Immediate Past Chair of the Health Estates and Facilities Management Association (HEFMA) • Director of HefmA Company Ltd • Director of HBE Ltd
Andrew George Non-Executive Director	• Director of Suffolk Mind • Interest in a property syndicate (offices in Diss and Eye) • Independent person for various councils in Suffolk
Denver Greenhalgh Director of Governance	• Nil
Simon Hallion Director of Operations (From 12 April 2017)	• Nil
Nick Hulme Chief Executive	• CEO at Colchester Hospital University NHS Foundation Trust • STP system lead
Dr Crawford Jamieson Medical Director (From 01 August 2017)	• West Suffolk CCG secondary care lead (To August 2017) • Wife is consultant physician at The Ipswich Hospital NHS Trust • Ad hoc work for Nuffield Health
Richard Kearton Non-Executive Director	• Consultant at GU Consulting
Martin Mansfield Interim Medical Director (To 31 July 2017)	• Nil
Mike Meers Director of ICT (From 01 September 2017)	• Director of ICT at Colchester Hospital University NHS Foundation Trust
Neill Moloney Managing Director	• Managing Director at Colchester Hospital University NHS Foundation Trust
Lisa Nobes Director of Nursing (To 31 March 2018)	• Nil
Elaine Noske Associate Non-Executive Director	• Paid employee BT
Simon Rudkins Interim Director of Finance (From 30 September 2017)	• Nil
Paul Scott Director of Finance and Performance (To 01 October 2017)	• Nil
Alison Smith Director of Community Services (From 25 September 2017)	• Nil
Helen Taylor Non-Executive Director	• Independent Chair of Waltham Forest Safeguarding Adults Board • Deben Associates Ltd
Claire Thompson Interim Director of Nursing (From 19 March 2018)	• Spouse MD of Vyaire Medical International (healthcare consumables company)
Tony Thompson Non-Executive Director	• Trustee for the Melton Trust • Paid employee of Tony Thompson Associates Ltd
David White Chair	• Non-Executive Director of Bullen Developments Ltd • Chairman at Colchester Hospital University NHS Foundation Trust • Trustee of John Innes Centre • Trustee of NUA UK

Corporate governance report

Directors' report

Research and development strategy

Our aim is to embed the management of research and innovation within normal Trust business, to set up and recruit patients faster and more effectively and to drive local partnerships and high calibre collaborations between the Trust and universities.

The Trust has well developed policies for research, development and intellectual property which places the Trust in an excellent position to take part in international clinical research studies to improve the quality of care provided to our patients. The research and development team is always available to provide support to staff wishing to take part in research studies.

Governance

Clinical governance is about continual improvement in the quality of care provided by NHS organisations, and ensuring that improvements, where needed, are made in a climate which is supportive, open and learning.

The hospital has a Quality Committee. Each division has a monthly risk and governance meeting where the groups have a vital role in bringing change, and considering clinical developments, service improvements, risk management and internal control issues throughout the Trust. The Trust complies with the clinical governance reporting framework issued in November 2002.

Emergency preparedness / major incident planning

The Trust has in place a major incident plan which is fully compliant with 'Handling Major Incidents: An Operational Doctrine' and accompanying NHS guidance on major incident/emergency preparedness and planning.

Listening and learning

We strongly encourage people who use the Trust – patients, their relatives and friends – to tell us what they think about their treatment and care. This helps us to continually improve services and to address problems quickly. Information leaflets and posters in wards, clinics and reception areas set out how people can make their views known.

Celebrating Our Team Ipswich Colleagues

Pre-registration Clinical Education team
Nominee: Team of the Year Award

Corporate governance report

Directors' report

We aim to respond to complaints within 28 working days from receiving the complaint. This year, 95.5% of complaints received were responded to in 28 working days or a revised timescale agreed with the complainant, against a Trust target of 100%. Every effort is made to contact each complainant within 24 hours of the complaint being logged by the complaints team. These calls, known as 24-hour courtesy calls, are made by a senior manager and are seen as an opportunity to:

- gain insight to understand the key issues that need to be resolved;
- take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response;
- explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter or a face-to-face meeting;
- help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously.

All complaints are assigned to a complaints coordinator who will liaise with the complainant and ensure the department responsible for investigating and responding to a complaint does so within the agreed time limits. Once a complaint investigation has been completed, it is checked to ensure all issues raised have been answered, before being passed to a member of the Executive team to review and sign the letter of response.

During 2017/18, the top three subjects for complaints were treatment, staff attitude and aspects of care.

Reopened complaints

During 2017/18, 45 (7%) of the complaints received were reopened. One of the main reasons for reopening a complaint has been identified as poor or inaccurate investigation. In these cases, complaints are returned to the investigating team for further explanation and clarification. Analysis of re-opened complaints is being undertaken to ensure that we understand why first responses are not meeting the satisfaction of complainants and to enable the complaints team to offer appropriate support.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

During 2017/18, seven cases were investigated by the Ombudsman as the complainant was unhappy with the response received from the Trust. Of these, one PHSO investigation has been completed and the case has not been upheld. At the time of reporting the other six cases were still under investigation. The Trust will be advised of the outcomes in due course.

Learning from complaints

While information drawn from surveys and other forms of patient feedback is important, every complaint received indicates that for that person or their family, they did not receive the high quality care they rightly expected.

Complaints are an important method by which the Trust assesses the quality of the service it provides. We take all complaints seriously and take action in response to them in various ways to improve the quality of care we provide.

We carry out an annual survey of 100 complainants to understand their experience of the complaints procedure and make changes to our processes where appropriate.

For more information about the complaints we received during last year, please refer to our Quality Account 2017/18, which is available on our website.

Corporate governance report

Directors' report

Compliments

Compliments are always welcome and they are passed on to the staff in the areas involved. They are an equally important method of identifying trends which enable good practice to be shared widely, as well as a morale boost for staff.

Many compliments are sent directly to the wards, usually in the form of cards, chocolates and biscuits.

When letters of compliment are sent to the Chief Executive, these are always responded to with a letter of thanks. All compliments are shared with the staff concerned. Over the course of a year there are many more compliments received than the number of formal complaints.

Comments and compliments received during the year were as follows:

Type	Q1	Q2	Q3	Q4	Total
Cards / gifts direct to wards	84	58	192	772	1,106
Your views matter	91	89	75	79	334
Comment / compliment cards	68	77	67	67	279
Total	**243**	**224**	**334**	**918**	**1,719**

PALS

The PALS team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. This is seen as a positive step towards taking more responsibility for issues as they arise.

PALS offers patients, carers and visitors:

- advice and signposting – helping to navigate the hospital and its services;
- compliments and comments – PALS can pass on compliments and ideas to improve services; and
- help to address non-complex issues informally, often preventing a formal complaint being raised.

Typical matters raised with PALS include:

- ward-related concerns such as pain management or discharge arrangements;
- litter from cigarette ends and staff smoking in groups;
- lost property;
- car parking concerns;
- resolving matters where patients are unable to contact the department of their choice by telephone.

During 2017/18, our PALS team dealt with 2,355 queries, compared with 2,578 in 2016/17.

Celebrating Our Team Ipswich Colleagues

Lara Burgess, student radiographer
Winner: Trainee of the Year Award

Corporate governance report

Directors' report

Serious incidents requiring investigation

Reporting incidents helps us to learn from them and decide whether we need to change the way we do things to improve patient safety, as well as identifying areas where we need to focus resources, such as training. We report our patient safety incidents to the National Reporting and Learning System (NRLS) so that information can be reviewed nationally for trends or problems.

Serious incidents requiring investigation (SIRIs)

Adverse events and SIRIs reported

For 2017/18, there have been the following adverse events (categorised as low harm to severe harm) reported on the Datix risk management computer system. The adverse events recorded below are all adverse events, not only those related to patients.

Type of adverse event	Number of adverse events
Abusive, violent, disruptive or self-harming behaviour	222
Access, appointment, admission, transfer, discharge	1,860
Accident that may result in personal injury	2,246
Anaesthesia	19
Clinical assessment (investigations, images and lab tests)	1,105
Consent, confidentiality or communication	435
Diagnosis, failed or delayed	85
Financial loss	3
Implementation of care or ongoing monitoring/review	2,636
Infrastructure or resources (staffing, facilities, environment)	550
Labour or delivery	442
Medical device/equipment	405
Medication	1,299
Other	309
Patient information (records, documents, test results, scans)	438
Security	63
Treatment, procedure	264
Totals:	**12,381**

Of these incidents, 162 were reported as SIRIs on the national Strategic Executive Information System (StEIS):

Type of adverse event	Number of SIRIs
Adverse media coverage or public concern	0
Allegation against staff	4
Diagnostic incident including delay meeting SI criteria	14
Infection control incident meeting SI criteria	5
Information governance breach	2
Maternity/Obstetric incident meeting SI criteria (mother/baby)	3
Medication incident meeting SI criteria	3
Pressure ulcers Grade 3 or 4 meeting SI criteria	91
Screening issues meeting SI criteria	0
Slip/trip/fall meeting SI criteria	18
Suboptimal care of the deteriorating patient meeting SI criteria	5
Surgical/invasive procedure incident meeting SI criteria	6
Treatment delay meeting SI criteria	11
Totals:	**162**

Corporate governance report

Directors' report

Learning from incidents

All reported incidents are investigated and lessons that can be learnt are shared at Clinical Delivery Group governance meetings, Divisional Board meetings, morbidity and mortality meetings and discussed at the Trust's Risk Oversight Committee.

It is important that when serious incidents occur, they are reported and investigated in a timely manner. This is not only to ensure that the correct action can be taken, but also to enable the Trust to learn from the incident to prevent it happening again and to reassure the patient involved that such incidents are taken seriously and thoroughly investigated.

The higher level incidents categorised as SIRIs are reported to the Ipswich and East Suffolk Clinical Commissioning Group. These incidents are investigated, a comprehensive report written and actions implemented, and the learning shared both within the organisation and the patient and/or their family.

The number of pressure ulcers recorded during 2017/18 has increased due to reporting changes to now include the reporting as SIRIs of all avoidable and unavoidable pressure ulcers.

Duty of candour

Open and honest communication with patients is at the heart of healthcare.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out some specific requirements which providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

As part of the Trust's process, patients or their relatives are informed of any such incidents. The Trust continues to work to improve the timeliness of follow-up letters to patients, their families or carers and to work with the families to individualise the level of engagement.

Failure to meet this regulatory standard may result in financial penalty. The Trust has not been subject to any penalties relating to Duty of Candour.

What are we doing to make improvements?

- We have made an information leaflet available to patients or their relatives who have been the subject of a serious incident (SIRI). The leaflet explains the process for investigating a SIRI and how patients and their families can get involved.
- We have formalised a family liaison officer role to support those patients and their relatives during the SIRI investigation process.

Never events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The list of never events for 2017/18, as defined by NHS Improvement (Revised Never Events Policy and Framework, 2015), are:

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post procedure
- Mis-selection of a strong potassium-containing solution
- Wrong route administration of medication
- Overdose of insulin due to abbreviations or incorrect device
- Overdose of Methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation
- Failure to install functional collapsible shower or curtain rails
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients

There are exclusions to each never event.

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Directors' report

Never events at The Ipswich Hospital NHS Trust

2015/16	2016/17	2017/18
5	4	1

Regrettably there was one never event during 2017/18 when a foreign object was retained post procedure. The patient has suffered no ill effects.

Surgical thermometer

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care, which was introduced in April 2012. The safety thermometer survey provides a snapshot of 'harm-free care' on a single day each month when every current inpatient is assessed for the presence of any of four harms (pressure ulcers, falls, catheter-acquired urinary tract infections, venous thromboembolism) within the previous 72 hours. These harms and the results are recorded on a national database which allows us to monitor the prevalence of these harms and to assess our performance in providing harmfree care.

Surgical safety checklist – national standards for invasive procedures

In 2016, following a review of national and local learning from the analysis of never events, serious incidents and near misses, NHS England developed National Safety Standards for Invasive Procedures (NatSSIPs), built on the good work around the World Health Organisation (WHO) Surgical Safety Checklist.

NatSSIPs are designed to help organisations provide safe care to patients undergoing invasive procedures in any healthcare setting, not just in the operating theatre.

The WHO Surgical Safety Checklist Review Group has been renamed Safer Invasive Procedure Oversight Group, broadening its remit as a result of the new recommendations from NHS England. The group has overseen the review of a new policy on Safer Invasive Procedures, and of clinical areas where invasive procedures are undertaken to ensure local standards of safe practice are applied. The group also oversees the modification of safety checklists based on feedback from serious incident investigations.

Going forward, the work within our Divisions will continue to incorporate these national recommendations in clinical practice and to provide assurance audits of compliance and quality of application, in order to maintain a safe environment for patients undergoing invasive procedures wherever they take place within the Trust.

Prompt payment code

The prompt payment code is a payment initiative developed by Government with the Institute of Credit Management (ICM) to "tackle the crucial issue of late payment and help small businesses".

Details of the code can be found at www.promptpaymentcode.org.uk The code does not include any targets but is a series of principles that all NHS organisations are expected to follow during the normal course of business. The hospital has signed up to and endorsed the code.

Details of the Trust's performance against the better payments practice code are disclosed in note 7.1 to the accounts.

Charging for information

The Ipswich Hospital NHS Trust complies with the Treasury's guidance on setting charges for information.

Corporate governance report

Statement of Directors' responsibilities

Directors' statement of disclosure to auditors

The Directors at Ipswich Hospital NHS Trust are not aware that there is any relevant audit information of which the NHS Trust's auditor is unaware. The Directors have taken all 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 NHS Trust's auditor is aware of that information. 'Relevant audit information' means information needed by the NHS Trust's auditor in connection with preparing their report.

The Directors have taken all the steps that they ought to have taken as directors in order to do the things mentioned above. They have made such enquiries of their fellow Directors and of the Trust's auditors for that purpose and taken such other steps (if any) for that purpose, as are required by their duties as Directors of the Trust to exercise reasonable care, skill and diligence.

Statement of directors' responsibilities in of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are 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.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Date 29 MAY 2018 **Chief Executive**

Date 29 MAY 2018 **Acting Director of Finance**

Corporate governance report

Statement of Accountable Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed: ..... **Chief Executive**

Date: 29 MAY 2018

Celebrating Our Team Ipswich Colleagues

Belle Parker, clinical educator
Nominee: Trainee of the Year Award

Corporate governance report

Governance statement

Scope of responsibility

As Accountable 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 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 acknowledge my responsibilities as set out in the *NHS Trust Accountable 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 the Ipswich Hospital NHS 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 The Ipswich Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

As Chief Executive, I am accountable for the overall risk management activity within the Trust. In discharging these responsibilities I have been assisted by the following Directors:

- the Managing Director and Deputy Chief Executive, who is responsible for ensuring risks relating to the day-to-day management of the Trust and those relating to the implementation of corporate strategies and business plans are managed. In addition to his own risk management responsibilities, he oversees the co-ordination and prioritisation of all risks reported to him from his Trust Executive colleagues;
- the Director of Finance who is responsible for managing the Trust's principal risks relating to the delivery of financial plans agreed by the Board;
- the Director of Nursing who is responsible for managing the principal risks relating to infection control as Director of Infection Prevention and Control; and, with the Medical Director, for managing the strategic development and implementation of safety and quality through the Quality Improvement Plan, for reporting this to the Board, through the Quality Committee, and for the assessment and reporting of clinical risk;
- the Director of Operations who is responsible for managing the Trust's risks relating to operational performance;
- the Director of Human Resources who is responsible for managing the Trust's principal risks related to Workforce Planning and the People, Organisation and Development enabling strategy;
- the Director of Information Communication and Technology who is the Senior Information Risk Officer (SIRO) responsible for the Trust's Information Systems, Security and Governance arrangements and the risks to the Information Management and Technology enabling strategy;
- the Director of Governance, who is responsible for ensuring that the Risk Policy is implemented and evaluated effectively;
- the Director of Estates, who is responsible for the safety of the Trust's premises and the risks to the Estates enabling strategy; and
- the Director of Community Services, who is responsible for managing the Trust's risks relating to Community Services operational delivery and performance and leading both the strategy for developing into an integrated care organisation and integration and collaboration within the East Suffolk Alliance Partnership

A complete description of the responsibilities, accountabilities and duties for risk management is given in the Trust Risk Management Policy. All statutory roles requiring executive board representation are held by members of the Trust executive listed above.

All staff members are trained in risk management at a level relevant

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to their role and responsibilities. Members of staff have had access to additional support and education to ensure they have the necessary skills and knowledge and are competent to identify, control and manage risk within their work environment from a number of specialist roles for example Health & Safety Advisors. All newly-appointed staff receive training at the compulsory corporate induction day. This includes their personal responsibilities as well as the necessary information and training to enable them to work safely and to recognise risk.

The Trust governance framework

The Trust's corporate governance structure is designed to ensure appropriate oversight and scrutiny and to ensure good corporate governance practice is followed.

Trust Board

The Trust Board is comprised of a Chair, five non-executive director members and five executive director members: the Chief Executive, Medical Director, Director of Nursing, Director of Finance and Managing Director. Eight other executive director members without voting rights attend each Trust Board meeting: the Director of Operations, the Director of Human Resources, the Director of Governance, the Director of Estates, the Director of ICT, the Director of Communications and the Director of Community Services.The Chair has a second and casting vote. The Company Secretary also attended all Board meetings. The Deputy Chair acts as Senior Independent Director.

The Board met a total of six times in public in 2017/18 with private Boards in the intervening months. Attendance was monitored throughout the year and there were 17 absences by a Non-Executive during this period and 18 from Executives. A Fit and Proper Persons check was carried out on all Board members and independently reviewed by the CQC as part of their 2017 Trust inspection. The CQC concluded that the Trust had a comprehensive Fit and Proper Persons Requirement (FPPR) process in place to ensure that directors were fit to carry out their responsible roles in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Board's Register of Interests was updated and presented at the May 2018 board.

There are six Committees of the Board all of which report to the Board. From April until September, this was through a highlight report, but from October until March, this was through a Chair's Key Issues report, which flags items for escalation, alert, assurance or information.

Audit Committee

In line with the requirements of the NHS Audit Committee Handbook and the NHS Codes of Conduct and NHS Code of Accountability, the Audit Committee has provided the Trust Board with an independent and objective review of the system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. The Trust is not required to comply with the UK Corporate Governance Code but its Corporate Governance arrangements draws on best available practice considered being relevant to the Trust.

The Audit Committee's membership is drawn exclusively from independent non-executive directors and has been supported by the work programmes of internal and external audit. This ensures independence from executive and operational management.

The Managing Director, Director of Finance, Director of Governance, Company Secretary, Head of Internal Audit and a representative from the external auditors normally attend the Audit Committee meetings. The Chief Executive attends at least once a year, for the meeting which reviews the Annual Report and Accounts. Other officers of the Trust are invited to attend the Audit Committee to report on standing items such as the review of risk and also as requested on exceptional items.

The Audit Committee met on six occasions during 2017/18 and provided independent monitoring and scrutiny of the processes implemented in relation to governance, risk and internal control. The Committee has reported its proceedings to the Trust Board following each meeting.

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Quality Committee

The Quality Committee has delegated authority to oversee the development of risk and clinical governance activities and to provide the Trust Board with assurance on all matters relating to quality, including patient safety, clinical effectiveness and patient experience.

It has been supported by the work of the Executive safety and quality committees (Patient Safety & Effectiveness, Patient & Carer Experience and Trust Safety) and reports from safety and quality leads.

The Chair of the Quality Committee, a Non-Executive Director, has reported on key issues to the Trust Board after each meeting.

Finance and Performance Committee

The Finance and Performance Committee has provided assurance to the Trust Board in the following areas: strategic financial and operational performance matters; delivery of in-year financial plans and cost improvement plans; the Trust's financial policies; long-term financial sustainability, and capital investment.

The Chair of the Finance and Performance Committee, a Non-Executive Director, has reported on key issues to the Trust Board after each meeting.

Nomination and Remuneration Committee

The Nomination and Remuneration Committee's role is to appoint, and, if necessary, dismiss the executive directors; establish and monitor the level and structure and reward of the Chief Executive and executive directors (subject, where applicable, to Treasury approval via NHS Improvement), ensuring transparency and fairness and consistency; develop and implement succession planning for key senior management posts; ensure that contractual terms on termination and any payments in respect of executive directors are lawful and represent value for money; and ensure all provisions regarding disclosure of remuneration, including pensions are fulfilled.

The Committee also has responsibility for assurance around the Fit and Proper Persons test for Board Directors, Non-Executive and Executive.

Charitable Funds and Sponsorship Committee

The Trust is also the corporate trustee of the Ipswich Hospital NHS Trust Charitable Fund (Registered Charity 1048827), which is overseen by the Charitable Funds and Sponsorship Committee, which is a Committee of the Board. The Board met as corporate trustee to approve the Ipswich Hospital charitable funds annual report and accounts for the year ended 31 March 2017, to approve the Letter of Representation and to receive the ISA2260 report from the external auditors.

Workforce, Development and Education Committee

The Workforce, Development and Education Committee provides the Trust Board with an independent and objective oversight of workforce and education issues; to ensure, suggest and make recommendations to support the Board in ensuring the Trust continues to maintain a fit for purpose workforce and is a place where people want to work and learn.

Transaction governance

In addition to the above standing committees, the board has met regularly during 2017/18 with the board of Colchester Hospital University NHS Foundation Trust in monthly Board to Board to review the Outline Business Case, Full Business Case and supporting documents, including due diligence reports and reports on pre- and post-transaction programmes. This forum was also supported by a Partnership Advisory Board (PAB) which oversaw risks relating to the transaction and programme delivery. The PAB meets and reports monthly to the boards of both Trusts.

Board effectiveness review

The previous external diagnostic of board and quality governance arrangements took place in 2014/15. The next external diagnostic will take place in 2018/19 following the transaction with Colchester Hospital University NHS Foundation Trust as part of an agreed S106 undertaking between Colchester Hospital University NHS Foundation Trust and NHSI.

The Executive Team carried out its annual self-review of leadership and governance against the

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NHSI Well-led framework during June 2017 and considered its performance against key lines of enquiry which included leadership capacity and capability, vision and strategy, culture of high quality sustainable care, accountability arrangements, risk management, data quality, internal and external engagement and systems for learning, continuous improvement and innovation and identified satisfactory compliance. The Trust's performance against the same criteria was independently assessed by the CQC during its inspection in August 2017 and confirmed as "good". This will be used as a framework to ensure that governance arrangements for the new Trust are designed to meet best practice as stated in the NHSI guidance.

In 2017/18 the Board has met on a monthly basis to enable more in-depth review of topics and to develop strategy and has undertaken a range of development activities with regular seminar time scheduled into its work programme. This time is used to ensure the board are up to date with key issues in essential areas, for example in safeguarding, but also as an opportunity to consider in depth the future strategic issues facing the organisation, such as the transition into an integrated care organisation and the potential long-term partnership with Colchester Hospital University NHS Foundation Trust. Board to Board meetings with the board of Colchester provided further opportunities to reinforce members knowledge of the activities taking place to support the transaction and its benefits, risks and mitigations.

During the year the Trust has continued to review the effectiveness of the operating model. Contributions from the leadership tiers across the organisation, including the Board, are used to identify the strengths, weaknesses and further opportunities for improved effectiveness.

The Trust's Corporate Governance Framework was updated and approved by the Board in August 2017 following an in-depth review of the Board Committees' Terms of Reference, Standing Orders, Schedule of Matters Reserved to the Board, Standing Financial Instructions and the Scheme of Delegation during March and April 2017.

Executive oversight of risk framework

The day-to-day management of the Trust is managed by four clinical divisions. Each division has its own leadership team and divisional board chaired by the Clinical Director, with an Associate Director of Nursing, and Head of Operations making up the triumvirate leadership that mirrors the composition of the Trust Board. They are supported by the Corporate Division for Human Resources, Finance, IT and Estates expertise.

Community services were transferred to the organisation in October 2017 and reporting structures have been replicating the embedded framework within the well-established three acute operational divisions. The target for full implementation by April 2018 was met.

The Trust continues to empower and embed the division accountability structures. The overarching intention remains one of supporting a clinically led organisation with a single line of accountability for all aspects of performance including patient safety, patient experience, operational standards, financial performance and staff engagement. This structure continues to secure the engagement of clinicians including doctors, nurses, midwives and allied healthcare professionals in the leadership of the organisation through an accountability framework.

Oversight, challenge and scrutiny of divisional risks is undertaken monthly at the Risk Oversight Committee which has Executive members and Non-Executive Director attendance.

The divisional leaderships and the executive directors meet monthly as an Executive Management Committee, which is responsible for ensuring the risks on the corporate risk register and Board Assurance Framework are managed. The committee submits a highlight report of the key issues to the Board.

Quality governance

Whistleblowing and speaking up

The Trust encourages staff to speak up about any concerns at work.

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The Board considers it to be a vital way in which the organisation learns and continues to improve services for our patients and the working environment for our staff.

In accordance with our duty of candour, the Board and leadership team are committed to providing an open and honest culture. A Freedom to Speak Up Guardian is in place (a joint appointment with Colchester Hospital University NHS Foundation Trust), to help raise the profile of raising concerns and to provide confidential advice and support to staff who wish to raise concerns or have issues about the way their concern has been handled. Underpinning this, a range of processes and interventions are in place to enable staff to report concerns promptly and to be supported in doing so, without fear of reprisal. This includes a standard integrated policy as recommended in the review by Sir Robert Francis into whistleblowing in the NHS, which was published on 1 April 2016 and updated during 2017. All of this will help to strengthen our approach to raising concerns for the benefit of all patients.

Serious incidents

All Board members are notified of Serious Incidents, high level complaints and clinical claims. The Trust reports all serious incidents and never events in line with the national and local frameworks.

There was one never event during 2017/18. This related to a retained cotton wool ball after a procedure. Investigation into the root causes is ongoing and once concluded appropriate action will be taken to ensure that appropriate safeguards are put in place to prevent recurrence.

The Trust has in place a policy for the implementation of Duty of Candour regulations and is able to evidence this being achieved in respects to being open with patients, their families and carers when things have happening giving rise to patient harm; however further work is required to deliver this consistently within the target to send follow-up letters within 10 days.

The Board receives a monthly report detailing all serious incidents, never events, high level complaints and claims which include lessons learned and actions being taken from investigations completed.

Quality Accounts

The Trust Board is 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.

The Quality Accounts have been prepared, and at this time are unaudited. The Quality Committee has reviewed a draft and the external auditors will present their report to a future meeting of the Audit Committee.

The Trust assures the quality and accuracy of its data, including elective waiting time data through a regular validation process internally, with additional checks by the Business Informatics Team to ensure the data reported is accurate, which includes ensuring all 52 week breaches have been confirmed by the service, checks on large movements and triangulation with other recording systems. Further independent assurances are made through internal audits of data quality, national validation programmes and third party support from specialist organisations with validation expertise.

Care Quality Commission (CQC) registration

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

The Care Quality Commission (CQC) carried out inspection visits between 30 August and 13 October 2017 and reported its findings to the Trust on 18 January 2018.

The 2017 hospital inspection report was reported to the Trust public Board in January 2018. The inspection rated the hospital as 'Good'.

An action plan has been developed to address the issues raised by the CQC and the Trust continues to champion continuous improvement across all divisions and departments. The CQC advised us that we must take action to improve the following:

- Mandatory training uptake
- Safeguarding training at level 3
- Equipment maintenance
- Environment for EBME department
- Oversight of Discharge Lounge
- Risk assessment of the ED environment for people presenting with mental health problems

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- Documentation of MEWS (ED)
- Documentation of first hour of care (CYP)

The action plan has been discussed with the Quality Committee, who are monitoring its progress on behalf of the board.

Other regulatory requirements

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes undertaking equality impact assessments to provide assurance that consultations relating to changes to any of our functions and services are not discriminatory. Where any remedial action is identified by the assessment, we develop and implement an action plan to address this.

The Trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Risk and control framework

The Trust responsibilities and accountabilities for risk management are described in the Trust risk management policy. Leadership for risk is driven by the Board of Directors through the Board Assurance Framework which keeps the Board informed of the key strategic risks affecting the Trust, the mitigations and sources of assurance, including gaps in control, gaps in assurance and actions to reduce risks to an acceptable level. There is clear risk ownership over who is the senior board-level risk owner.

At a workshop in April 2017, the Board considered and agreed the principles regarding the risk that the Trust is prepared to seek, accept or tolerate in the pursuit of its objectives and has captured these in a Risk Appetite Statement, as follows:

Financial

The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential and is prepared to be bold, but not reckless in its decisions. With regard to treasury management, however, the Trust takes a more cautious approach to investment. It is prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. When making its decisions, it will consider value and benefits, not just the cheapest price. Resources are allocated in order to capitalise on opportunities.

Compliance/Regulatory

The Board has a cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so and the gain will outweigh the adverse consequences.

Innovation

The Board has a flexible view of innovation that supports quality, patient safety and operational effectiveness. Its strategic objective to embrace new ideas to deliver new, technology enabled, financially viable ways of working leads it to pursue innovation and challenge current working practices. It is willing to devolve responsibility for non-critical decisions on the basis of earned autonomy.

Quality

The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of "no harm" at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation is strong. When taking decisions involving

Corporate governance report

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choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients.

Reputation

The Board has an open view over the management of the Trust's reputation. The Board is willing to take decisions that are likely to bring scrutiny of the organisation where the potential benefits outweigh the risks and sees new ideas as potentially enhancing the reputation of the organisation.

Commercial

The Board has a flexible view of commercial risk. It is willing to pursue business opportunities with the potential for high returns alongside commercial activities of a more established nature, taking a balanced view of risk and reward and on the basis of earned autonomy.

The above statement was agreed at a public meeting of the Board in May 2017.

Risk assessment

Risk Management Policy

The Risk Management Policy and supporting policies and procedures set out the key responsibilities for ensuring risk is managed within the organisation, including ways in which risk is identified, evaluated and controlled.

Risk management training

The Trust requirements for risk management training are described in the Mandatory Training Policy.

Risk management, Board Assurance Framework and key risks

Risk management is taken into account in the organisation in a variety of ways. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. Local clinical delivery groups (CDGs) develop and maintain local risk registers and oversee the management of adverse incidents. Risk processes are monitored and reviewed by the monthly Risk Oversight Committee meeting, Executive Management Committee, Quality Committee, Finance and Performance Committee, Workforce Development and Education Committee and Audit Committee.

Board Assurance Framework (BAF)

The BAF provides the Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of principal objectives are at risk due to a gap in control and/or assurance.

Each risk has an identified risk owner who is responsible for managing and reporting on the overall risk. The identified risk owner is an Executive, or other, Director. An assurance committee is also identified to assure the Board that each principal risk is being monitored, gaps in controls identified, and processes put in place to minimise the risk to the Trust.

The designated Assurance Committees of the Board are the Quality Committee (Clinical Risk) and the Finance and Performance Committee (Financial and Contractual Performance) and Workforce, Development and Education Committee (Workforce Risk). The Audit Committee monitors the risk management process overall.

Following the establishment of a new Trust strategic plan in March 2017 and the approval of the enabling strategies in June 2017, a new draft BAF was developed which identified the risks to the revised strategic objectives in those documents. Members of the Trust Executive carried out individual risk assessments on their areas of responsibility during June and July 2017 and the first working version of the BAF was produced at the end of July. This was first presented to the Board in September 2017.

Risks scoring 15 and above migrate to the Board Assurance Framework (BAF), as such six risks were identified with a net severity of 15+. For each of the risks (detailed below) the BAF described the processes and controls in place to manage the risk, and what further action is necessary to control the risk. The BAF is reviewed quarterly at a public Board meeting and the risks scoring 15+ at each public Board meeting. The risks escalated during 2017/18 included the following:

- Risk of failure to develop a combined strategy for integration with alliance partners, impacting on the STP ambitions to limit growth in acute activity. Risk of insufficient capacity, skills and abilities in the area of transformational

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management to realise the benefits within the Trust's STP portfolio;

- Inability to plan for financial sustainability may result in the QIP strategy failing to deliver;
- Inability to have sufficient nursing staff on duty may result in delayed or rushed care for patients, impacting on patient experience, potential clinical harm, delays in patient flow and poor job satisfaction;
- Inability to have sufficient medical staff on duty, impacting on patient experience, potential clinical harm, deterioration in outcomes, delays in patient flow and poor job satisfaction.
- Inability to resource IT strategy delivery, resulting in limitations or delays to the delivery of enabling programmes of work to support the delivery of the Trust Strategy;
- Restrictions in central DH capital impacting on the Trust's ability to invest in delivering the Strategy or get the benefits from the long term partnership.

These risk issues, the key controls in place to manage them, the actions in hand to further reduce their likelihood and impact and the outcomes of those actions are discussed at the monthly Executive Risk Oversight Group, monthly Board meetings and at meetings of the Board's assurance committees.

Compliance with the NHS provider licence

The Trust assessed its risks to compliance with the NHS provider licence condition 4 in June 2017 and identified only one high risk, which was already listed as one of its principal risks in the BAF (above) – which was the risk to its financial sustainability. This was submitted to NHSI as requested by the 30 June 2017 deadline. The risk is mitigated through having robust systems, structures and processes for financial and budgetary control and performance management, a CIP programme to identify efficiency savings and a long-term financial model which, through its partnership with Colchester Hospital University NHS Foundation Trust, will reduce the size of the combined projected deficits of both Trusts over a five-year period.

The other risks identified were assessed as medium or low due to the established governance systems and structures as described in this statement relating to escalation and accountability, the delegated responsibilities to Directors and subcommittees as agreed in the Scheme of Delegation, and the established information flows between the board, Board committees and the rest of the organisation through the accountability framework.

Performance against national priorities

The Trust Integrated Performance Report (IPR) is reported to the Trust Board at each of its public meetings. The IPR brings together key metrics used by NHS Improvement, NHS England and Commissioners in evaluating Trust performance.

During 2017/18 the Trust has demonstrated satisfactory performance against some of the key performance indicators. Key achievements this year include:

- Compliance with the Cancer 2-week and 31-day target.
- Achievement of the Trust MRSA trajectory reporting zero cases in year.
- Achievement of the C.difficile trajectory for no more than 18 cases in 2017/18 with six attributable cases.

Exceptions to good performance during the year included the following:

- Failure to achieve compliance with the 18-week incomplete pathway threshold of 92% across the year at a Trust level of 89.7% (delivery not sustained through core winter pressure period).
- Failure to achieve compliance with the 95% threshold for A&E four-hour waits across Type 1 and Type 3 new attendances. Full year compliance stood at 87.86%.
- Failure to achieve the 99% compliance required on diagnostic tests undertaken within 6 weeks, achieving 98.32% (predominantly reflecting a reliance on locum consultant radiologist support to meet ultrasound demand).
- Failure to achieve compliance with the requirement to cancel no more than 1% of operations on the day for non-clinical reasons, achieving 1.38% (again particularly reflecting pressures in the core winter period).

Performance against the key performance indicators are

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reported monthly to the Finance and Performance committee, with a particular focus on areas of non-compliance or deteriorating performance in order to ensure that credible action plans and trajectories for improvement are established and monitored.

Data security / Information governance

The Trust has an information security policy which states that as Trust Chief Executive, I am responsible, through nominated employees, for the protection of the Trust's information and have delegated authority from the Trust Board to take any necessary measure to protect the Trust's information. I have a Director of IM&T and Information Directorate which is responsible for formulating appropriate standards, guidelines and policies according to business and security current best practice to ensure the protection of information and continued processing of information. There is an IM&T Security Policy in place, which gives clear guidance to all staff of their responsibilities for data security. The eHealth Programme Group ensures that any clinical or business system development has been formally assessed to ensure compliance with Information Governance security standards.

As part of NHS information governance rules, details of Serious Incidents involving data loss or a breach of confidentiality have to be reported. Patients and the public can be reassured that the Trust takes security and patient confidentiality very seriously. In 2017/18, the Trust reported 42 Level 1 incidents and two Level 2 incidents relating to breaches of patient confidentiality, compared with 41 Level 1 incidents and four Level 2 incidents in 2016/17. Information governance training and awareness have increased to prevent Level 2 incidents which are reportable to the Information Commissioner's Office (ICO).

Of the Level 2 incidents reported, that were reported to the ICO, one of which related to inappropriate access to patient data. Following investigations, two members of staff received disciplinary action. The ICO took no further action and was satisfied with the Trust's policies and training. The other incident related to a member of staff that dropped in error a paper operating theatre list in a corridor on Trust grounds. This was found by a member of the general public who handed it straight in to a receptionist. The ICO took no action and was happy with the Trust policies and training and supported the Trust's strategy to work paperlight.

The Trust carried out an assessment of its compliance with the Department of Health information governance toolkit, the outcome of which was a compliance score of 84% (2017/18).

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

The Board receives a monthly report from the Director of Finance, on financial performance. Financial performance is reviewed at the Executive and Clinical Management Committees and by the Finance & Performance Committee, which in turn, provides a formal report to the Trust Board in the form of the Integrated Performance Report.

The Trust had an initial planned deficit of £18.1m in 2017/18. The Trust posted a final deficit of £13.3m in 2017/18, including receipt of £11.0m Sustainability and Transformation funding. The Trust operated in a very challenging environment in 2017/18 with significant risks to delivery of the financial plan identified through business planning. The environment within which the Trust operates has remained challenging, including the impact of winter pressures; these factors meant the Trust had to open more capacity than planned during the last quarter and had to staff it with locum and agency staff which came at a premium cost. The Trust delivered 95% of its cost improvement programme for the year at a value of £14.9m.

The Trust routinely reviews its budgetary controls system via the internal audit function; no areas within finance were found to be less than satisfactory during the year. Divisional teams signed up to delivering their budgets at the start of the year after a comprehensive business planning process. These budgets were not delivered in two of the four Divisions, due to risks identified at budget setting not being managed although overall the Trust achieved a financial position significantly ahead of plan. These issues were spotted early

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and financial recovery plans were developed to try and address the risks with stretch targets agreed.

The Trust regularly benchmarks itself against other Trusts through the use of reference costs. During 2017/18, the Trust has worked closely with system partners across the Suffolk and North East Essex footprint with a view to identifying sustainable opportunities across a number of partner organisations. The Trust is currently undertaking work to merge with Colchester Hospital University NHS Foundation Trust.

Counter fraud

The Trust is required under the terms of the Standard NHS Contract and in accordance with the NHS Protect Standards for Providers: Fraud, Bribery and Corruption to ensure appropriate counter fraud measures are in place.

The Local Counter Fraud Group (LCFG) with expertise from the accredited Local Counter Fraud Specialist (LCFS) adopts a risk-based approach to counter fraud work, using the NHS Protect Risk Assessment Tool and the incidence of local frauds to identify areas of potential vulnerability. Relevant local proactive exercises are consequently built into the Trust's annual counter fraud work plan, which is overseen by the Audit Committee. The Audit Committee receives assurance on fraud deterrent from regular reports from the Trust's Local Counter Fraud Group and from the Local Counter Fraud Specialist.

The LCFS helps to foster an anti-fraud culture within the Trust through the delivery of training at induction for all staff. This features content on counter fraud and on compliance with the UK Bribery Act 2010.

There was a programme of counter fraud and anti-bribery activity, supported by the LCFG and LCFS whose proportionate annual proactive work plan to address the identified risks, was monitored by the Director of Finance, the deputy Director of Finance and the Audit Committee. Counter Fraud material was disseminated to staff regularly through newsletters, leaflets and posters. Fraud and Bribery Act awareness information was also provided to all staff at induction via the 'Mandatory Training Handbook'.

The LCFS issued a number of Fraud Alerts/Bulletins during 2017/18 relating to subjects such as mandate fraud, increased threats from cyber-attacks, potential telephone fraud, tax refund scams, identity fraud, phishing emails, charitable fraud and IT support fraud which are ongoing fraud issues nationally within the NHS and the wider public sector.

During the year, the NHS Counter Fraud Authority carried out a focused Quality Assessment of compliance against the 2017/18 NHS Protect Standards for providers. This review concluded that the Trust was rated "red" against the "Hold to Account" standard due to insufficient evidence being provided to show that the necessary work had been carried out. An action plan was established to address the concerns raised, progress against which will be monitored by the Local Counter Fraud Group.

Internal audit

An annual audit plan is undertaken by Internal Audit and monitored by the Audit Committee. The table on the next page describes the internal audit reviews undertaken in 2017/18 and the level of assurance provided.

There were three areas of limited assurances and the reasons for that opinion were as follows:

Patient Safety – Chaperoning

There were weaknesses identified in the record keeping of whether a patient had a chaperone when required, processes for monitoring compliance with the chaperoning policy were not yet fully embedded and separate training on chaperoning is not currently offered to staff members.

Partnerships – NEESPS

Although due diligence had been undertaken during the restructuring of the pathology services and transfer of hosting to North East Essex and Suffolk Pathology Services (NEESPS), weaknesses were identified in the management arrangements and controls in place. These included a delay in the review of the specifications and related terms as referred to in the Contract Variation Agreement, and weaknesses in reporting on the transformational/CIP plan for 2018/19. It was noted that a number of issues had come to

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Audit	Assurance Level Provided
Health and safety	Reasonable
Procurement and contract management.	Substantial
Pharmacy stock controls	Substantial
Estates – facilities management	Reasonable
Patient safety – medical equipment	Reasonable
Waiting list management and data quality	Reasonable
IT projects – endoscopy system	Substantial
Accountability framework	Substantial
Capital programme monitoring	Substantial
2016/17 C/Fwd clinical audit plan	Reasonable
Financial reporting and budgetary control	Reasonable
VFM – cost improvement plans	Reasonable
Financial systems	Substantial
Payroll (including expenses)	Reasonable
IM&T – information governance toolkit	Reasonable
BAF and risk management	Reasonable
Patient safety – chaperoning	Limited
Governance – Community Services	Limited

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Jonathan Benmore, senior therapy radiographer, Radiotherapy
Nominee: Leader of the Year Award

light after the service transfer date to NEESPS which, although now resolved, would benefit future projects by undertaking a lessons learnt exercise.

Clinical Quality – Mortality – Governance and Data Quality

The accuracy of the Trust's reported mortality information is affected by significant coding delays, as well as some delays issuing discharge summaries when patients have died.

Review of the effectiveness of risk management and control

As Accountable 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 information provided in the annual report, quality 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 reports. I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee, the Workforce, Education and Development Committee and the Finance and

Corporate governance report

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Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion is one of 'Reasonable' assurance that the Trust has adequate and effective management, internal control processes to manage the achievement of its objectives.

My review is also informed by executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and 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 Trust Board and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement is in place.

The Trust Board and its committees meet regularly and, as part of their consideration, keep arrangements for internal control under review through discussion and approval of policies and practice. The Audit Committee has provided the Trust Board with an independent and objective review of financial and corporate governance, and internal financial control within the Trust.

The Audit Committee has received reports from external and internal audit including reports relating to the Trust's counter fraud arrangements. The Trust Executive Directors and managers, and the Chairs of the Quality Committee, Workforce, Development and Education Committee and Finance and Performance Committee of the Board, have provided the Trust Board with reports on risk management, performance management and safety and quality governance.

I have also been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee and Executive Directors. These groups each receive regular reports and updated action plans to manage or monitor progress on major risks, as defined in their respective terms of reference. A plan to address weaknesses and ensure continuous improvement of the system is in place.

A number of external agencies and other assessors measure and report on the Trust's performance against statutory requirements or best practice. These groups examine many potential high risk areas. The results of their work are considered and acted on where necessary by the relevant executive director. All significant external scrutiny reports are also reported to the appropriate Committee for monitoring in line with the Trust policy on External Agency Visits, Inspections and Visits.

Conclusion

The foregoing statement identifies a number of incidences of control weakness, identified both through internal reviews and through external scrutiny from NHSI, the CQC and other sources. Detailed plans have been reported to the Board and its committees to improve those control issues in these areas and I am satisfied that those issues have been or are being actively addressed.

I have considered the factors described in the NHS Improvement guidance on the 2017/18 annual governance statement in respect of significant issues. Of the matters identified in this statement, the following is considered to be significant:

Financial sustainability and breakeven duty.

The Trust reported a significant deficit in 2017/18 and will be required to deliver cost improvement efficiency savings of £23.2m in 2018/19 to deliver its control total. As the Trust is not expected to achieve financial balance in the medium term, the Trust's external auditors are unable to conclude that the Trust has put in place proper arrangements to secure the sustainable deployment of resources and will refer the matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the Trust's reported deficit break even position.
The Trust will continue to focus on delivering realistic levels of savings from sharing internal cost improvements and working with partners in the health system

Corporate governance report

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to see if there are benefits from sharing support service functions, having stronger clinical alliances, working better with colleagues in primary care, social services and the community to avoid the continued rise in attendances at hospital and the associated costs to the health and social care system. The planned merger with Colchester Hospital University NHS Foundation Trust represents a significant step forward towards returning to a position of financial sustainability.

In all other regards, I am satisfied that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives.

Accountable Officer

The Accountable Officer is Nick Hulme, who is the signatory to the Annual Governance Statement.

Accountable Officer:
Nick Hulme, Chief Executive

Organisation:
The Ipswich Hospital NHS Trust

Signature:

Date:
29 May 2018

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Community COPD team
Nominee: Team of the Year Award

Remuneration and staff report

Remuneration policy

The Nomination and Remuneration Committee acts with delegated authority from the Trust Board.

The purpose of the Nomination and Remuneration Committee is to identify and appoint candidates to fill all the executive director positions and for determining their remuneration and other conditions of service.

In order to meet these objectives its responsibilities include:

Nomination

- Reviewing the size, structure and composition of the Board and leadership needs of the Trust, making recommendations for change as necessary
- Succession planning for executive Board positions
- Reviewing executive directors' other significant commitments for potential conflicts and/or capacity issues

Remuneration

- Determining the Trust's remuneration policy and the specific remuneration and terms of service of:
  - the Chief Executive;
  - the executive directors; and
  - other staff as determined by the Board.
- Determining the targets for any performance related pay scheme contained within the policy
- Reviewing performance and objectives of the Chief Executive and other executive directors
- Ensuring that contractual terms of termination are fair and adhered to
- Making recommendations to the Board on the level of any additional payments contained within the policy
- Ensuring that remuneration packages are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience to lead the Trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the Trust

The Nomination and Remuneration Committee comprises the Trust Chair, who chairs the committee, and all non-executive directors of the Board. At the discretion of the Chair, the Chief Executive and Director of Human Resources may be present to advise, but not for any discussions concerning their personal remuneration.

A quorum will consist of the Chair (or his/her nominated representative) and at least two other non-executive directors.

Executives' pay is reviewed annually. The committee is presented with benchmarking information which compares each directors' salary to similar posts in the NHS. Decisions to uplift salaries are based on this information, internal quality, affordability, and whether there has been a significant change in the directors' portfolio during the year. In accordance with Guidance on Pay for Very Senior Managers in NHS Trusts, all proposals for a remuneration package exceeding £142,500 are referred for approval from NHS Improvement, Department of Health, the Minister of State for Health and Her Majesty's Treasury.

Chief Executive – six months
Executive directors – three months.

The Trust did not have a bonus scheme in operation during 2017/18.

Pension contributions

The Trust made contributions totalling £17.2 million in the year to the NHS Pensions Agency, as per note six to the accounts. Note seven in the Trust's accounts provide further details as to the nature of the pension scheme and accounting practice in relation to associated liabilities. Details of the pension benefits of the Trust's senior managers are also given in the Remuneration Report.

Expense payments (excluding benefit in kind expenses)

The Trust has made expense payments to 13 Directors totalling £15,700 during 2017/18. In 2016/17, there were payments made to 13 Directors totalling £7,700.

Better payments practice code

Details of the Trust's performance against the better payments practice code are disclosed in note 7 to the accounts.

Remuneration and staff report

Single total figure remuneration table (subject to audit)

Salary and pension entitlements of Board members

Salary and pension entitlements of Board members 2017/18	Salary (Bands of £5,000) £000	Long Term Perfomance pay and Bonuses (Bands of £5,000) £000	Benefits in kind (Rounded to nearest £100) £00	All pension-related benefits (Bands of £2,500) £000	TOTAL (Bands of £5,000) £000
Name and title					
Nick Hulme Chief Executive	90–95	0	4	52.5–55	145–150
Neill Moloney Managing Director	120–125	0	1	42.5–45	165–170
Paul Scott Director of Finance and Performance (To 01/10/17)	75–80	0	0	15–17.5	90–95
Simon Rudkins Acting Director of Finance and Performance (From 30/09/17)	50–55	0	0	212.5–215	265–270
Dr Crawford Jamieson Trust Medical Director (From 01/08/17)	125–130	0	1	420–422.5	545–550
Martin Mansfield Acting Medical Director (To 31/07/17)	50–55	5–10*	1	7.5–10	65–70
Lisa Nobes Director of Nursing and Quality	105–110	0	2	0	105–110
David White Trust Chair	25–30	0	0	0	25–30
Tony Thompson Non-executive Director	5–10	0	0	0	5–10
Andrew George Non-executive Director	5–10	0	1	0	5–10
Laurence Collins Non-executive Director	5–10	0	0	0	5–10
Helen Taylor Non-executive Director	5–10	0	2	0	5–10
Richard Kearton Non-executive Director	5–10	0	4	0	5–10

*Clinical Excellence Award.

In May 2016 Nick Hulme and David White were appointed Chief Executive and Chairman of Colchester Hospital University NHS Foundation Trust respectively. The total remuneration received during 2017/18 for both roles across The Ipswich Hospital NHS Trust and Colchester Hospital University NHS Foundation Trust for Nick Hulme and David White was £212,000 and £60,000 respectively. In addition, in January 2018 Neill Moloney was appointed Managing Director at Colchester Hospital University NHS Foundation Trust. The total remuneration received during 2017/18 for both roles across The Ipswich Hospital NHS Trust and Colchester Hospital University NHS Foundation Trust was £143,000.

During 2017/18, Martin Mansfield had joint roles as acting Medical Director and clinician. His remuneration for his role as a clinician during this period was £24,000.

Benefits in Kind relate to mileage claims in excess of the HMRC tax free allowance.

Remuneration and staff report

Single total figure remuneration table (subject to audit)

Salary and pension entitlements of Board members

Salary and pension entitlements of Board members 2016/17	Salary (Bands of £5,000) £000	Long Term Perfomance pay and Bonuses (Bands of £5,000) £000	Benefits in kind (Rounded to nearest £100) £00	All pension-related benefits (Bands of £2,500) £000	TOTAL (Bands of £5,000) £000
Name and title					
Nick Hulme Chief Executive	70–75	0	4	52.5–55	125–130
Neill Moloney Managing Director	140–145	0	3	115–117.5	255–260
Paul Scott Director of Finance and Performance	145–150	0	3	80–82.5	230–235
Barbara Buckley Trust Medical Director (To 30/11/16)	30–35	5–10*	3	235–237.5	275–280
Martin Mansfield Acting Medical Director (From 19/05/16)	65–70	5–10*	1	20–22.5	95–100
Lisa Nobes Director of Nursing and Quality	100–105	0	3	242.5–245	345–350
David White Trust Chair	25–30	0	5	0	25–30
Alan Bateman Non-executive Director (To 06/12/16)	0–5	0	0	0	0–5
Tony Thompson Non-executive Director	5–10	0	1	0	5–10
Andrew George Non-executive Director	5–10	0	2	0	5–10
Laurence Collins Non-executive Director	5–10	0	1	0	5–10
Helen Taylor Non-executive Director (From 21/04/16)	5–10	0	1	0	5–10
Richard Kearton Non-executive Director (From 21/04/16)	5–10	0	3	0	5–10

*Clinical Excellence Award.

Remuneration and staff report

Pensions entitlement table (subject to audit)

Pension benefits of Board members

Pension benefits – Board members 2017/18							
Name	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (Bands of £5,000) £000	Lump sum at retirement age related to accrued pension at pension age at 1 April 2017 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2018 £000	Cash equivalent transfer value at 1 April 2017 £000	Real increase/decrease in cash equivalent transfer value £000
Nick Hulme	0–2.5	5–7.5	50–55	155–160	1,144	1,064	80
Neill Moloney	0–2.5	0	45–50	120–125	753	687	66
Paul Scott	0–2.5	0	35–40	95–100	592	545	47
Simon Rudkins	7.5–10	22.5–25	25–30	60–65	385	245	140
Dr Crawford Jamieson	17.5–20	45–47.5	60–65	160–165	1,116	769	347
Martin Mansfield	0–2.5	0–2.5	40–45	125–130	875	845	30
Lisa Nobes	0	0	50–55	0	603	610	0

Pension benefits – Board members 2016/17							
Name	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2017 (Bands of £5,000) £000	Lump sum at retirement age related to accrued pension at pension age at 1 April 2016 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2017 £000	Cash equivalent transfer value at 1 April 2016 £000	Real increase in cash equivalent transfer value £000
Nick Hulme	0–2.5	5–7.5	50–55	150–155	1,053	954	99
Neill Moloney	5–7.5	12.5–15	45–50	120–125	680	585	95
Paul Scott	2.5–5	7.5–10	35–40	95–100	540	474	66
Barbara Buckley	10–12.5	30–32.5	75–80	230–235	1,634	1,276	239
Martin Mansfield	0–2.5	5–7.5	40–45	125–130	836	777	53
Lisa Nobes	10–12.5	0	50–55	0	604	458	146

Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pensions Scheme.

Pension liabilities

Details of the NHS Pensions Scheme are disclosed in note 6.3 to the accounts.

Directors' entitlement for loss of office (subject to audit)

Directors are not entitled to any contractual payment for loss of office. No such payments were made to departing Directors in 2017/18.

Remuneration and staff report

Fair pay (ratios) disclosure (subject to audit)

Cash equivalent transfer values

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 are the member's accrued benefits and contingent spouse's pension payable from the 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 disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Median staff pay disclosure

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

The banded remuneration of the highest paid director in The Ipswich Hospital NHS Trust in the financial year 2017/18 was £125,051 (2016/17, £147,500). This was 4.4 times (2016/17, 5.2) the median remuneration of the workforce, which was £28,746 (2016/17, £28,292). The highest paid Director in 2016/17 was the Director of Finance and Performance, but not in 2017/18 as the Director left the Trust in October 2017.

In 2017/18, 85 medical consultant employees (2016/17, 16) received remuneration in excess of that of the highest-paid director. Remuneration ranged from £6,843 to £299,912 (2016/17 £3,254 to £320,132).

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.

Remuneration and staff report

Fair pay (ratios) disclosure (subject to audit)

Staff costs	2017/18			
	£000s Total	£000s Permanently employed	£000s Agency/Contract	£000s Other
Salaries and wages	157,403	139,550	9,862	7,991
Social security costs	13,376	12,485	-	891
Apprenticeship levy	729	729	-	-
NHS pension scheme	17,247	16,391	-	856
Other pension costs	-	-	-	-
	188,755	**169,155**	**9,862**	**9,738**
Less: Recoveries in respect of seconded staff	782	782		
	187,973	168,373		
Costs capitalised as part of assets	**453**	**407**	-	**46**
Total employee benefits (excluding capitalised costs)	**187,520**	**168,232**	**9,862**	**9,692**

Staff costs	2016/17			
	£000s Total	£000s Permanently employed	£000s Agency/Contract	£000s Other
Salaries and wages	148,593	131,329	10,952	6,312
Social security costs	12,793	12,136	-	657
NHS pension scheme	16,051	15,417	-	634
Other pension costs	-	-	-	-
	177,437	**158,882**	**10,952**	**7,603**
Costs capitalised as part of assets	481	362	74	45
Total employee benefits (excluding capitalised costs)	**176,956**	**159,244**	**11,026**	**7,648**

Remuneration and staff report

Fair pay (ratios) disclosure (subject to audit)

Staff numbers by WTE	2017/18			2016/17
	Total number	**Permanently employed number**	**Other**	Total number
Average staff numbers				
Ambulance staff	**2**	2	0	2
Administration and estates staff	**889**	852	37	923
Healthcare assistants and other support staff	**903**	786	117	786
Medical and dental staff	**491**	465	26	494
Nursing, midwifery and health visiting staff	**1,367**	1,240	127	1,291
Nursing, midwifery and health learning staff	**0**	0	0	6
Scientific, therapeutic and technical staff	**472**	456	16	411
Healthcare scientists	**53**	50	3	69
Total	**4,177**	**3,851**	**326**	3,982

Staff gender breakdown	2017/18		2016/17	
	Number		Number	
	Female	**Male**	Female	Male
Contracted staff	**3,833**	**943**	3,480	890
The Trust maintains a bank of staff who can be called on as required	**2,905**	**571**	2,425	418
Total	**6,738**	**1,514**	5,905	1,308

Board gender and payscale breakdown	2017/18		2016/17	
	Number		Number	
	Female	**Male**	Female	Male
Non-executive director	2	5	2	6
Very senior manager	5	9	4	4
Total	**7**	**14**	6	10

Remuneration and staff report

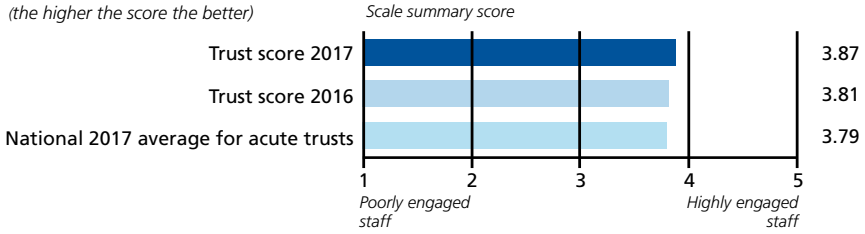
Staff report

The Trust continues to work towards the achievement of the NHS pledges as outlined in the NHS Constitution to ensure that all staff feel trusted, actively listened to, provided with meaningful feedback, treated with respect at work, have the tools, training and support to deliver compassionate care, and are provided with opportunities to develop and progress.

As part of our cultural change, we have an ambition that our staff will highly recommend Ipswich Hospital as:

- a place to work;
- a place to receive treatment;
- a place to be trained.

Overall staff engagement



National NHS Staff Survey

This year's national NHS staff survey highlighted a high level of staff engagement at the Trust as this diagram shows:

It was sent to all staff in October 2017. 1930 staff responded, a 46% response rate, which was the same as 2016 but above average for acute trusts (44%).

Results show that there has been an increase in staff engagement since 2016. All key findings that make up the staff engagement indicator are better than average when compared with all acute trusts and one has an increase on 2016.

The key findings measuring staff engagement were:

- Staff members perceived ability to contribute to improvements at work
- Their willingness to recommend the Trust as a place to work or receive treatment
- The extent to which they feel motivated and engaged in their work.

Analysis of key findings

- There has been no statistically significant changes in 17 out of 32 of the key findings since the 2016 survey.
- 15 key findings were better than average and seven were in the top 20% of acute trusts.
- Compared to other acute trusts we are below average in one key finding, which is also in the bottom 20% of acute trusts.
- Our overall staff engagement score is above average when compared to trusts of a similar type (3.79) and there is an increase on 2016 from 3.81 to 3.87.
- Our overall recommendation score is above average when compared to trusts of a similar type (3.76) and there is an increase on 2016 from 3.80 to 3.85.
- We have made significant improvement and it is important that we learn from what has worked well and replicate it.

Remuneration and staff report

Staff report

Celebrating Our Team Ipswich Colleagues

Stewart Taylor,
Frailty Assessment Base administrator
Winner: Living the Values
Colleague of the Year Award

Recruitment of staff

Recruitment drive initiatives have also been undertaken to address difficult to fill posts and to reduce the number of times that staff are required to work extra hours. We have held three international nurse recruitment campaigns and taken a number of actions to address our 'difficult to recruit to' posts. As part of the workforce strategy review and non-mandatory training provisions, we will be looking at training, information, and communication needs and other ways of addressing this.

The Trust's vision and values were developed by staff, patients and key stakeholders and apply to all with crucial linkage between good patient and workforce experiences. We plan to continue focusing on having conversations with staff on what matters to them.

Listening to and engaging with our staff

The findings from the staff survey will help inform targeted, robust actions for continuous improvement as essential steps to restore our workforce position and ensure the Trust is a good place to work and train.

Workforce Race Equality Standard (WRES)

The NHS WRES was introduced in 2015 to help enable Black Minority Ethnicities (BME) to have equal access to career opportunities and fair treatment in the workplace after research indicated potentially less favourable treatment of these groups in the NHS.

The Trust measures progress against nine indicators of workforce race equality which focus on any differences between the experience and treatment of White and BME staff. This also marks the level of BME representation at senior management and board level and helps to plan evidence-based action. A national database will be benchmarking national and local progress.

Equality and Diversity

Equality is about fair and inclusive treatment. It is protected in law with the aim that we can all live and work in a society where everyone can participate, have opportunity to fulfil potential and fair access to services and employment.

Diversity supports equality, recognising and understanding the broad range of differences which makes someone unique such as their culture, belief, gender, age, physical or mental abilities, and also their experiences, needs, expectations or responsibilities.

Being fair and inclusive means valuing and respecting a person's diverse requirements, thoughts and contribution. Equality and diversity work in unison to achieve all this.

Remuneration and staff report

Staff report

Why this agenda is important

The people we serve and employ are becoming increasingly diverse with varied needs, but everyone needs to feel valued and included and treated fairly and respectfully. The Trust, our patients, staff and stakeholders have all identified and made a commitment to this within our shared values and our expectations of conduct. Everyone is responsible for supporting this agenda.

Our responsibilities and ensuring delivery

Equality, firmly underpinned in the Equality Act 2010, ensures people do not receive unfair treatment or be subjected to discrimination or harassment due to their age, race, gender, belief, sexual orientation, transgender, in marriage or civil partnership or in pregnancy or maternity. To ensure we meet these responsibilities, the Workforce, Development and Education Committee overviews this agenda for the workforce, whilst the Quality Committee reviews service provision.

NHS Equality Delivery System

Like all NHS organisations, the Trust uses the Equality Delivery System (EDS2) to implement equality and diversity strategies and the Public Sector Equality Duty. There are four overarching goals:

- better health outcomes;
- improved patient access and experience;
- a representative and supported workforce;
- inclusive leadership.

More details can be found at www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Engagement and involvement with patients, staff and stakeholders

A key part of EDS2 is the identification of stakeholders from patients, staff, or local interest groups to secure meaningful engagement to help assess and evaluate where we are and how to progress. This partnership approach to engagement and involvement with communities helps us focus on what matters most for our patients, communities and staff.

During the year, we have also set up an equality and diversity champions group, which is open to any colleague working across the Trust.

Embedding equality and diversity

EDS2 helps identify, develop and implement objectives to continue to make real, sustainable improvement to our services and working conditions whilst delivering better outcomes and benefits to meet the needs of staff and service users.

The equality objectives and priorities are also aligned to the Trust's organisational priorities to ensure relevance and to realise full benefits within the Trust's corporate, workforce and patient strategies. This helps embed the agenda into our governance structure and into all activities for effective implementation.

NHS Accessible Information Standard (AIS)

Application of the AIS helps to meet needs in relation to a disability, impairment or sensory loss which affects the ability to communicate. The AIS applies to patients, carers or parents. We try to address any information/communication support needs to enable better access to services and care to give a better patient experience.

Commitment to promoting equality and diversity in the workforce, and inclusive leadership is crucially associated with increased patient-centred innovation, care, staff morale and access to a wider talent pool.

Workforce Race Equality Standard (WRES)

EDS2 covers all areas of diversity across services and the workforce. The WRES focuses on workforce and race as a particular NHS need to improve performance in this area where there is potentially less favourable treatment and experience of BME staff in the NHS.

Workforce Disability Equality Standard (WDES)

The WDES is a new development to improve performance. We will also be looking to improve services for those with a disability.

Remuneration and staff report

Staff report

Care Quality Commission (CQC) / equality diversity and human rights agenda

Equality and diversity is inspected by the CQC as part of the 'well led' domain of the NHS inspection programme. This includes analysis of EDS2 and WRES reports, action plans and how issues arising from equality data are addressed.

Our commitment continues

The Trust aims to achieve a diverse workforce reflective of and sensitive to the needs of the community. We will work towards eliminating discrimination, promoting equal opportunity and removing barriers to fair and equal treatment of staff and patients.
Support from the Trust

Board ensures full ownership and accountability for this agenda. The Board is involved in and approves equality developments and understands their role, and legal requirements.

Staff sickness

The Trust's rolling 12-month sickness rate is at 4.03% (12 months to 31 March 2018). This compares to 3.99% in March 2017.

The most recent published data for the acute medium trusts (January 2018) lists the sickness rate as 4.80%, which is higher than that recorded for The Ipswich Hospital NHS Trust at 4.61%.

Freedom to Speak Up Guardian

Our first Freedom to Speak Up Guardian, Tom Fleetwood, took up his post on 1 December 2016. Tom works across both Ipswich and Colchester hospitals for three days each week.

Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.

Tom grew up around the Colchester area and was a Non-Executive Director of Colchester Hospitals University NHS Foundation Trust until taking up the guardian role. He had a long career in the army, the last three years of which were spent as the Commander of Colchester Garrison.

The Freedom to Speak Up Guardian role was developed as a recommendation of the Francis Review, looking at failings in care at Mid-Staffordshire Trust to make sure that hospitals have a dedicated 'go to' person for when staff need to speak up and other avenues are not suitable. Acting in a genuinely independent capacity, Tom will work alongside both Boards and executive teams to continue developing both organisations as open and transparent places to work.

Remuneration and staff report

Staff report

Guardian of Safe Working Hours (GSWH)

The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors and dentists are not working unsafe hours. The Guardian of Safe Working Hours is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service for doctors and dentists in training. It is a role intended to be undertaken by a consultant or someone of equivalent seniority.

The guardian reports directly to the Trust Board and is independent of the management structure within the organisation. Dr Mark Garfield, a consultant anaesthetist, has been appointed to this role for the Trust.

To fulfil this role, the guardian will:

- act as the champion of safe working hours;
- receive exception reports and record and monitor compliance against terms and conditions;
- escalate issues to the relevant Executive Director, or equivalent for decision and action;
- intervene to reduce any identified risks to doctors/dentists or to patient safety;
- undertake a work schedule review where there are regular or persistent breaches in safe working hours; and
- distribute monies received as a consequence of financial penalties, to improve training and service experience.

The guardian is a member of the regional network, which will support the development of the GSWH role and the sharing of best practice.

Consultancy

The Trust paid £423k for consultantancy services during 2017/18.

Celebrating Our Team Ipswich Colleagues

Rebecca Walker, Crisis Action Team service lead
Winner: Leader of the Year Award

Remuneration and staff report

Staff report

Off-payroll engagements (not subject to audit)

For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	41
Of which, the number that have existed:	
for less than 1 year at the time of reporting	22
for between 1 and 2 years at the time of reporting	14
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	2

Most off-payroll engagements are made through established employment agencies and the Trust does not consider that these carry a significant risk of taxes not being properly accounted for. Where payment is not made via such an agency, the Trust conducts checks and seeks assurances regarding employment status.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	32
Of which:	
Number assessed as caught by IR35	28
Number assessed as not caught by IR35	4
Number engaged directly (via PSC contracted to the entity) and are on the entity's payroll	28
Number of engagements reassessed for consistency/assurance purposes during the year	1
No. of engagements that saw a change to IR35 status following the consistency review	0

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:

Date:
29 May 2018

Celebrating Our Team Ipswich Colleagues

Karen Case, clinical educator
Nominee: Trainee of the Year Award

Remuneration and staff report

Staff report

Staff sickness absence and ill-health retirements (not subject to audit)

	2017/18	2016/176
	Number	Number
Total hours lost	**305,942**	282,393
Total staff years	**3,860**	3,612
Average working hours lost	**79.26**	78.18
Persons retired early on health grounds	**2**	4

Exit packages and severance payments (subject to audit)

There were no exit packages agreed in 2017/18.

	2016/17			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Total number of exit packages	Total cost of exit packages
Staff banding	Number	£s	Number	£s
Less than £10,000	1	4,660	1	4,660
£25,001 – £50,000	1	42,061	1	42,061
Total	**2**	**46,721**	**2**	**46,721**

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change terms and conditions of service. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages – other departures analysis (subject to audit)

There were no exit packages for other departures in 2017/18 (2016/17 none).

There were no non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary (2016/17 none).

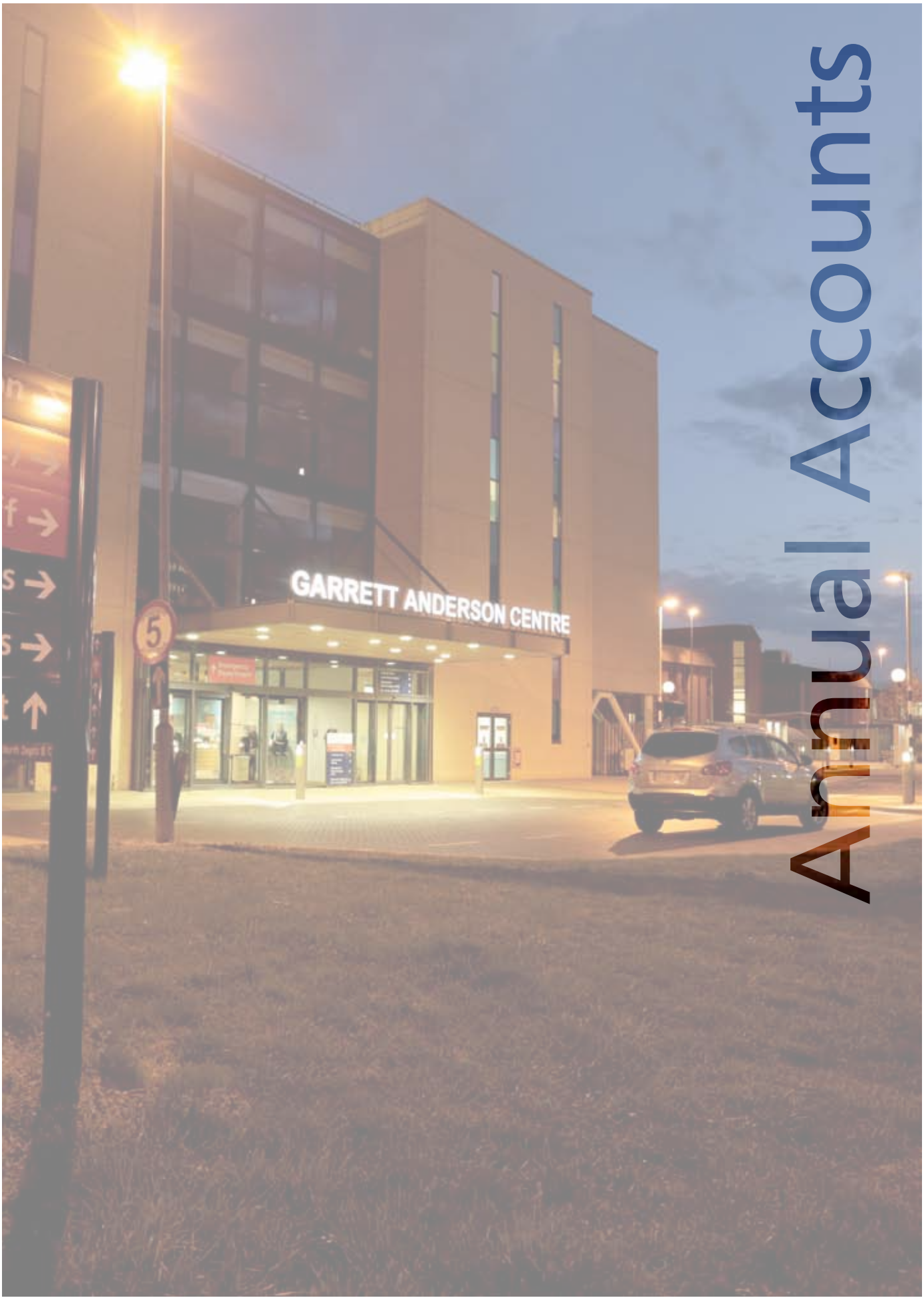
This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Glossary

Glossary of Terms	
A&E	• Accident and Emergency (Casualty)
CCG	• Clinical Commissioning Group
CHP	• Combined Heat and Power
DH	• Department of Health
DNACPR	• Do Not Attempt Cardio Pulmonary Resuscitation
DToC	• Delayed transfer of care
ED	• Emergency Department
IHT, the hospital, the Trust, we	• The Ipswich Hospital NHS Trust
NHS	• National Health Service
NHSI	• NHS Improvement
OCS	• Provider of facilities services to the Trust
PALS	• Patient Advice and Liaison Service
PHSO	• Parliamentary and Health Service Ombudsman
RTT	• Referral to treatment
SDMP	• Sustainable Development Management Plan
STP	• Sustainability Transformation Plan
WTE	• Whole time equivalent



Annual Accounts

Ipswich Hospital NHS Trust

Draft Annual Accounts for the period

1 April 2017 to 31 March 2018

FOREWORD TO THE ACCOUNTS
THE IPSWICH HOSPITAL NHS TRUST

These accounts for the year ended 31 March 2018 have been prepared by The Ipswich Hospital NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE IPSWICH HOSPITAL NHS TRUST

Opinion on financial statements

We have audited the financial statements of The Ipswich Hospital NHS Trust (the Trust) for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18 and the Accounts Directions issued by NHS England.

In our opinion the financial statements:

- give a true and fair view of the financial position of The Ipswich Hospital NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

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

Use of our report

This report is made solely to the Board of Directors of The Ipswich Hospital NHS 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 Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Material uncertainties related to going concern

We draw attention to Note 1.1 in the financial statements which sets out the Directors' assessment of the financial position of the Trust in the context of the National Health Service framework in which it operates and their conclusion that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Our opinion is not qualified in respect of this matter.

Other information

The Accountable 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 information in the Remuneration and Staff Report

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

In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

Matters on which we are required to report by exception

Report to the Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 29 May 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 as the Trust has breached its statutory breakeven duty.

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, except for the matters referred to in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion on use of resources

The Trust set an original budget for 2017/18 which anticipated a £27.2 million deficit. With the use of the Sustainability and Transformation Fund (STF), the Trust was forecasting a deficit of £18.1 million.

Although it achieved its control total as agreed with NHS England, the Trust has reported a deficit of £12.1 million in its financial statements for the year ended 31 March 2018.

The Trust does not yet have plans to secure a return to a breakeven position in the medium term and is forecasting a further deficit of £22.8 million for 2018-19. The Trust is not expected to achieve financial balance and meet its statutory target to breakeven in the medium term.

These matters are evidence of significant weaknesses in arrangements to ensure that the Trust deployed its resources to achieve planned and sustainable outcomes for taxpayers and local people.

Other matters

We have nothing to report in respect of the following other matters in relation to which the Local Audit and Accountability Act 2014 requires us to report to you if:

- in our opinion the Governance statement does not comply with the guidance issued by NHS England; or
- except as reported above, we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

Responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities, the Directors are 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 they determine 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 Directors are 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 informed by the Department of Health and Social Care of its intention for dissolution without transfer of services or function to another entity or for the Trust to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Chief Executive is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the audit of the financial statements

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

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

Auditor's other responsibilities

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

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

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

Certificate

We certify that we have completed the audit of the accounts of The Ipswich Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

BDO LLP

Lisa Clampin
For and on behalf of BDO LLP
Ipswich, UK

29 May 2018

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

Statement of Comprehensive Income for year ended 31 March 2018

	NOTE	2017/18 £000	2016/17 £000
Gross employee benefits	6.1	(187,520)	(176,956)
Other operating costs	5	(142,271)	(137,568)
Revenue from patient care activities	3	283,727	259,477
Other operating revenue	4.1	37,902	36,974
Operating deficit from continuing operations		**(8,162)**	**(18,073)**
Investment Revenue		21	18
Finance costs		(2,804)	(2,548)
Deficit for the financial year		(10,945)	(20,603)
Public dividend capital dividends payable		(1,164)	(1,735)
Retained deficit for the financial year		**(12,109)**	**(22,338)**
Other comprehensive income			
Impairments and reversals taken to the revaluation reserve		(515)	1,376
Total comprehensive expense for the year		**(12,624)**	**(20,962)**
Financial performance for the year			
Retained deficit for the year		**(12,109)**	(22,338)
IFRIC 12 adjustment (including IFRIC 12 impairments)		**(983)**	(256)
Impairments (excluding IFRIC 12 impairments)		**106**	7,557
Adjustments in respect of donated/gov't grant asset reserve elimination		**(446)**	(2,539)
Adjusted retained deficit		**(13,432)**	**(17,576)**

NHS Trusts have a statutory requirement to break even year on year. The Department of Health has determined that certain items should be excluded from the breakeven calculation. Further details are given in note 19.1

* IFRIC 12 is the interpretation of International Financial Reporting Standard 12, which deals with extra statutory concessions. The Trust's Private Finance Initiative (PFI) scheme is covered by this standard, as detailed in note 1.10.

The notes on pages 12 to 36 form part of this account.

Statement of Financial Position as at 31 March 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets		4,838	5,094
Property, plant and equipment	8	137,275	133,896
Trade and other receivables	9.1	3,179	1,410
Total non-current assets		**145,292**	140,400
Current assets			
Inventories		5,339	5,042
Trade and other receivables	9.1	26,364	27,966
Cash and cash equivalents	10	1,356	943
Total current assets		**33,059**	33,951
Total assets		**178,351**	174,351
Current liabilities			
Trade and other payables	11	(33,838)	(40,396)
Borrowings	12	(1,727)	(1,471)
DH Revenue support loan	12	(17,324)	-
Provisions	15	(295)	(568)
Total current liabilities		**(53,184)**	**(42,435)**
Total assets less current liabilities		**125,167**	131,916
Non-current liabilities			
Provisions	15	(989)	(1,037)
Borrowings	12	(25,956)	(25,064)
DH Revenue support loan	12	(51,440)	(48,802)
Total non-current liabilities		**(78,385)**	(74,903)
Total assets employed		**46,782**	57,013
Financed by			
Public dividend capital		95,895	93,502
Revaluation reserve		24,599	26,310
Income and expenditure reserve		(73,712)	(62,799)
Total taxpayers' equity		**46,782**	57,013

The notes on pages 12 to 36 form part of these accounts.

The financial statements on pages 8 to 36 were approved by the Board on 29 May 2018 and signed on its behalf by

Chief Executive:  Date: 29 MAY 2018

Statement of Changes in Equity for the Year Ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Retained Earnings £000	Total £000
Balance at 1 April 2017	**93,502**	**26,310**	**(62,799)**	**57,013**
Changes in Taxpayers' equity for 2017-18				
Deficit for the year	-	-	(12,109)	**(12,109)**
Other transfers between reserves	-	(1,190)	1,190	**-**
Impairments	-	(3,163)	-	**(3,163)**
Revaluations	-	2,648	-	**2,648**
Transfer to retained earnings on disposal of assets	-	(6)	6	**-**
Reclassification Adjustments				
Temporary and Permanent PDC received - cash	2,393	-	-	**2,393**
Net recognised revenue/(expense) for the year	2,393	(1,711)	(10,913)	(10,231)
Taxpayers' equity at 31 March 2018	**95,895**	**24,599**	**(73,712)**	**46,782**

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

	Public dividend capital £000	Revaluation reserve £000	Retained Earnings £000	Total £000
Balance at 1 April 2016	**92,752**	**26,168**	**(41,695)**	**77,225**
Changes in Taxpayers' equity for 2016-17				
Deficit for the year	-	-	(22,338)	**(22,338)**
Other transfers between reserves	-	(1,234)	1,234	**-**
Impairments	-	1,376	-	**1,376**
Reclassification Adjustments				
Temporary and Permanent PDC received - cash	750	-	-	**750**
Net recognised revenue/(expense) for the year	750	142	(21,104)	(20,212)
Taxpayers' equity at 31 March 2017	**93,502**	**26,310**	**(62,799)**	**57,013**

Information on reserves

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

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

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows For the Year Ended 31 March 2018

	NOTE	2017/18 £000	2016/17 £000
Cash flows From Operating Activities			
Operating deficit		(8,162)	(18,073)
Non-cash income and expense:			
Depreciation and amortisation	8	9,922	9,641
Impairments and reversals		(877)	7,301
(Increase)/decrease in inventories		(297)	(578)
(Increase)/decrease in Trade and Other Receivables		1,996	(12,342)
Increase/(decrease) in Trade and Other Payables		(6,588)	6,216
Increase/(decrease) in non cash provisions		(323)	179
Net Cash Outflow from Operating Activities		**(4,329)**	**(7,656)**
Cash flows from investing activities			
Interest received		21	18
Payments for Property, Plant and Equipment		(10,341)	(11,686)
Payments for intangible assets		(1,080)	(890)
Payments for Other Financial Assets		-	(4,554)
Proceeds of disposal of assets held for sale (PPE)		-	662
Net Cash Outflow from Investing Activities		**(11,400)**	**(16,450)**
Net Cash Outflow before Financing		**(15,729)**	**(24,106)**
Cash flows from Financing Activities			
Gross Temporary and Permanent PDC Received		2,393	750
Loans received from DH - New Revenue Support Loans		19,962	29,752
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(1,850)	(2,143)
Interest Paid		(2,726)	(2,535)
PDC Dividend paid		(1,084)	(1,653)
Other financing activities		(553)	-
Net Cash Inflow from Financing Activities		**16,142**	24,171
NET INCREASE IN CASH AND CASH EQUIVALENTS		**413**	65
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**943**	878
Cash and Cash Equivalents (and Bank Overdraft) at year end	10	**1,356**	943

NOTES TO THE ACCOUNTS

1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2017-18 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The financial statements have been prepared on a going concern basis. In accordance with IAS 1, management have made an assessment of the Trust's ability to continue as a going concern. For the financial year commencing 1st April 2018 the Trust has forecast a deficit of £15.3 million and within this forecast is a cost improvement programme requiring £23.2 million of efficiencies and savings. In order to fund this deficit, the Directors are seeking interim financial support for 2018/19 of £15.3 million from the Department of Health and Social Care. As at 31 March 2018, borrowings from the DHSC in the form of revenue loans amounting to £68.8 million has been provided to the Trust and discussions are on-going with regard to the further support required.

Although contracts for 2018/19 have been signed with commissioners, the Trust has not yet received formal confirmation in respect of the interim financial support at the time of signing the accounts. This represents a material uncertainty for the Trust and there is a presumption that additional working capital support will again be required in 2019/20. However, the Trust has made no decision to request dissolution from the Secretary of State and has no reason to believe that financial support will not be provided.

In January 2017, both Colchester Hospital University NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT) identified that a Long-Term Partnership (LTP) was essential to their sustainability. In March 2018 a Full Business Case was approved by both Boards, with the aim or merging to form the new "East Suffolk and North Essex Foundation Trust" with effect from July 2018. The Boards of the two Trusts consider that a full merger will be for the benefit of improved care for patients and create a more sustainable future for both organisations.

Whilst to all intents and purposes this will be a merger of equal standing between the two Trusts, the formal legal and accounting basis of the transaction will constitute an acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust.

The clinical strategy for the future has started to be developed for future public consultation post organisational merger, but the Trust Boards have committed last year that there will need to be A&E, maternity and acute medical services at both Colchester and Ipswich hospital sites in the future.

The Trust has submitted a plan for 2018/19 as a stand alone entity and therefore in the unlikely event that the merger does not proceed will continue to operate on that basis. The Trust has planned income in 2018/19 of £326.0m, the substantial portion of which is backed by contract all of which had been signed as at 31 March 2018.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health and Social Care Group Accounting Manual 2017/18, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it was unable to continue as a going concern.

1.2 Accounting Convention

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

1.3 Critical Judgements and Key Sources of Estimation Uncertainty

In the application of the Trust’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.3.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

PFI

Payments in respect of the Trust's PFI agreement are apportioned between ongoing maintenance, interest charges and repayment of the capital sum outstanding in accordance with an agreed formula which is designed to yield a representative split of costs into the respective categories, and to eliminate the PFI creditor by the end of the agreement.

Non-Consolidation of Charitable Funds

IFRS10 requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS10 defines a subsidiary as "an entity...that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities." The Trust is Corporate Trustee of the Charitable Fund and meets the definition of control.

Materiality is an overriding consideration in preparation of the accounts. The International Accounting Standards Board (IASB) states that "Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements".

The net assets of the Charitable Fund amount to about 3% of the Trust net assets. Charitable fund income is about 0.3% of Trust income. The Directors therefore consider that the significant amount of work which would be necessary to consolidate the accounts of the Charitable fund with those of the Trust is not justified on the grounds of materiality.

1.3.2 Key Sources of Estimation Uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Depreciation, Amortisation and useful economic lives

The Trust's basis for determining these estimates is explained in note 1.7.

Revaluation of Property, Plant and Equipment

The Trust engaged valuers (Gerald Eve LLP) to review the Trusts Estate and provide updated valuations as at 31 March 2018. As part of this process, the Trust requested a valuation of the Trusts main hospital (land) on an alternative site basis.

It is the Trust's judgement that the current site is not essential to the provision of healthcare locally and that an alternative site has therefore be considered when determining the valuation; on the basis that it is at least as beneficial in serving the local population, both in terms of location and accesibility. The location identified which in the Trust's view satisfies this criteria, is the British Sugar site on Sproughton Road, approximately 4 miles from the main hospital, with close access to the A14. The Trust's main hospital land has therefore been valued this basis.

Revisions in 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.

As per accounting policy 1.7 and note 8 the Trust values specialised properties on a depreciated replacement cost (DRC) basis. Property, Plant and Equipment on the Statement of Financial Position has a carrying value of £137.3m

Valuations of specialised properties are undertaken by a professional RICs qualified valuer. The valuation date was 31 March 2018.

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.

The key assumptions that are most likely to affect 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 which would be incurred in constructing the modern

A djustments 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 actual asset being valued. This adjustment is made by the valuer based on his knowledge and experience, and takes into account physical deterioration, and functional and economic obsolescence.

Pensions

Critical judgements have been applied in accounting for pensions. These are detailed in note 6.3.

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. Final agreement of income is reached after closure of the accounts. The figures included in the accounts are reflective of activity performed.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, Plant and Equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost 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.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value in existing use at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Valuations are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The alternative site method is used by the Trust.

Land and buildings that are surplus to requirements are valued at fair value using IFRS 13, unless there are restrictions on the entity or the asset which would prevent access to the market and are valued at current value in existing use as above.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.8 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Government Grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured in accordance with the accounting policy for property, plant and equipment, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.11 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.12 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 15.

1.13 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.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

1.14 Financial Assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Trust financial assets are classified as Loans and Receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

The amount of any impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.15 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health and Social Care are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 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.

1.17 Public Dividend Capital (PDC) and PDC Dividend

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.

1.18 Accounting Standards that have been issued but have not yet been adopted

The following changes to standards issued by the International Accounting Standards Board (IASB) have not yet been adopted within the FReM, and are therefore not applicable to Department of Health and Social Care group accounts in 2017/18. Other than IFRS16 (see below), none of these are expected to impact upon the Trust financial statements.

IFRS 9 Financial Instruments: Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is therefore not permitted.

IFRS 15 Revenue from Contracts with Customers: Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

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 therefore not permitted. The Trust is aware that this standard will have an impact, the extent of which is still to be quantified.

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.

IFRIC 22 Foreign Currency Transactions and Advance Consideration: Application required for accounting periods beginning on or after 1 January 2018.

IFRIC 23 Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1 January 2019.

NOTES TO THE ACCOUNTS

2. Operating Segments

The Chief Operating Decision Maker of Ipswich Hospital NHS Trust is the Trust Board, with reporting to the Trust Board and decision making, based on the Trust as a whole.

The Ipswich Hospital NHS Trust has one operating segment which is the provision of healthcare services. The revenue from patient and non patient care activities is detailed below in Notes 3 and 4.

3. Revenue from Patient Care Activities

3.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
Elective income	53,359	52,937
Non elective income	71,503	65,551
First outpatient income	20,990	18,436
Follow up outpatient income	22,120	21,851
A & E income	11,604	10,431
High cost drugs income from commissioners (excluding pass-through costs)	25,601	26,998
Other NHS clinical income	49,590	46,967
Community services income from CCGs and NHS England*	18,175	(91)
Income from other sources (e.g. local authorities)	5,067	9,462
Private patient income	843	687
Other clinical income	4,875	6,248
Total income from activities	**283,727**	**259,477**

3.1 Income from patient care activities (by source)

	2017/18 £000	2016/17 £000
NHS England	47,725	47,878
Clinical commissioning groups*	224,459	197,003
Other NHS providers	8,045	10,442
NHS other	6	85
Non-NHS:		
Local Authorities	892	1,365
Private patients	843	687
Overseas patients (non-reciprocal)	199	203
Injury costs recovery	758	910
Other Non-NHS patient care income	800	904
Total income from activities	**283,727**	259,477

***** This includes income in relation to the provision of Suffolk Community Services which transferred to the Trust from 1 October 2017

4 Other Operating Income

4.1 Other operating income

	2017/18 £000	2016/17 £000
Recoveries in respect of employee benefits	2,803	3,017
Education, training and research	10,677	10,094
Charitable and other contributions to expenditure	19	-
Receipt of charitable donations for capital acquisitions	875	2,934
Non-patient care services to other bodies	835	1,404
Income generation (other fees and charges)	3,747	3,630
Sustainability and transformation fund income	11,049	7,847
Rental revenue from operating leases	226	205
Other income	7,671	7,843
Total other operating income	**37,902**	36,974
Total Operating Revenue	**321,629**	296,451

Included in other income is a grant for £2.5m received from Colchester Hospital University NHS Foundation Trust.

NOTES TO THE ACCOUNTS

4 Other Operating Income (continued)

4.2 Overseas Visitors Disclosure

	2017/18 £000	2016/17 £000
Income recognised this year	199	203
Cash payments received in-year	59	74
Amounts added to provision for impairment of receivables	82	64
Amounts written off in-year	26	35

5. Operating expenses

	2017/18 £000	2016/17 £000
Total Services from NHS Bodies*	12,630	1,700
Purchase of healthcare from non-NHS and non-DHSC bodies	12,043	8,233
Remuneration of non-executive directors	65	68
Supplies and services - clinical (excluding drugs costs)	25,186	28,813
Supplies and services - general	14,654	15,351
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	36,390	34,042
Consultancy costs	423	185
Establishment	7,690	9,293
Premises	7,035	6,026
Transport (including patient travel)	313	307
Depreciation on property, plant and equipment	8,586	8,473
Amortisation on intangible assets	1,336	1,168
Net impairments	(877)	7,301
Increase in provision for impairment of receivables	215	1,913
Increase in other provisions	46	5
Change in provisions discount rate(s)	9	78
Audit fees payable to the external auditor**		
audit services- statutory audit	51	73
other auditor remuneration (external auditor only)	34	12
Internal audit costs	130	124
Clinical negligence	13,185	12,030
Legal fees	211	173
Insurance	49	45
Education and training	628	965
Rentals under operating leases	353	261
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	815	806
Hospitality	92	69
Losses, ex gratia & special payments	331	262
Other	648	(208)
Total Operating Expenses (excluding employee benefits)	**142,271**	137,568
Employee Benefits		
Employee benefits excluding Board members	186,221	175,960
Board members	1,299	996
Total Employee Benefits	187,520	176,956
Total Operating Expenses	**329,791**	314,524

*Services from NHS bodies does not include inter-NHS expenditure which is more suitably classified elsewhere, e.g. within Supplies and services - clinical.

** The limitation on Auditor's liability is £1m (2016/17: £1m)

NOTES TO THE ACCOUNTS

6 Employee Benefits

6.1 Employee Benefits

	2017/18 Total £000	2016/17 Total £000
Employee Benefits - Gross Expenditure		
Salaries and wages	157,403	148,593
Social security costs	13,376	12,793
Apprenticeship levy	729	-
Employer's contributions to NHS pensions	17,247	16,051
Total Employee Benefits	**188,755**	177,437
Less: Recoveries in respect of seconded staff	**782**	-
	187,973	177,437
Employee costs capitalised	**453**	481
Employee Benefits excluding capitalised costs	**187,520**	176,956

6.2 Retirements due to ill-health

During 2017/18 there were 2 early retirement from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £101k (£247k in 2016/17).

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

6.3. Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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

NOTES TO THE ACCOUNTS

7. Better Payment Practice Code

7.1 Measure of compliance

	2017/18 Number	**2017/18 £000**	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	78,433	190,957	83,491	203,731
Total non-NHS trade invoices paid within target	34,230	84,274	44,994	135,360
Percentage of non-NHS trade invoices paid within target	**43.64%**	**44.13%**	53.89%	66.44%
NHS Payables				
Total NHS trade invoices paid in the year	1,977	25,519	1,597	11,586
Total NHS trade invoices paid within target	725	9,119	733	5,135
Percentage of NHS trade invoices paid within target	**36.67%**	**35.73%**	45.90%	44.32%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

The financial position of the Trust impacted on the 30 day performance as careful management of scarce cash resources was required all year.

NOTES TO THE ACCOUNTS

8.1 Property, Plant and Equipment

	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2017	**5,485**	**105,061**	**3,025**	**37,718**	**8,948**	**3,371**	**163,608**
Additions of Assets Under Construction			3,205				**3,205**
Additions Purchased	-	2,647	-	3,184	419	7	**6,257**
Additions - Purchases from Cash Donations & Government Grants	0	577	252	46	-	-	**875**
Additions Leased (including PFI/LIFT)				1,687			**1,687**
Reclassifications	-	2,671	(3,739)	487	136	24	**(421)**
Disposals other than for sale	-	-	-	(527)	-	-	**(527)**
Impairments/reversals charged to operating expenses	215	-					**215**
Impairments/reversals charged to reserves		(3,163)					**(3,163)**
Revaluations	680	1,727	-	241	-	-	**2,648**
Valuation/gross cost at 31 March 2018	**6,380**	**109,520**	**2,743**	**42,836**	**9,503**	**3,402**	**174,384**
Depreciation							
At 1 April 2017	**-**	**105**	**-**	**21,085**	**6,130**	**2,392**	**29,712**
Disposals other than for sale	-	-	-	(527)	-	-	**(527)**
Impairments/reversals charged to operating expenses		(704)		42			**(662)**
Charged during the year	**-**	**4,217**	**-**	**3,037**	**1,050**	**282**	**8,586**
At 31 March 2018	**-**	**3,618**	**-**	**23,637**	**7,180**	**2,674**	**37,109**
Net book value at 31 March 2018	**6,380**	**105,902**	**2,743**	**19,199**	**2,323**	**728**	**137,275**
Asset financing:							
Owned - purchased	6,380	76,306	2,743	12,497	2,272	671	**100,869**
Finance leased	-	2,023	-	5,587	-	-	**7,610**
On-SoFP PFI contracts and other service concession arrangements	-	22,098	-	-	-	-	**22,098**
Owned - government granted	-	394	-	143	-	1	**538**
Owned - donated	-	5,081	-	972	51	56	**6,160**
Total at 31 March 2018	**6,380**	**105,902**	**2,743**	**19,199**	**2,323**	**728**	**137,275**

8.2 Property, Plant and Equipment prior-year

	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2016	**5,485**	**99,705**	**6,816**	**39,007**	**7,694**	**3,344**	**162,051**
Additions of Assets Under Construction			2,837				**2,837**
Additions Purchased	-	2,182		1,496	446	-	**4,124**
Additions - Purchases from Cash Donations & Government Grants		141	2,295	498			**2,934**
Additions Leased (including PFI/LIFT)	-	367		712			**1,079**
Reclassifications	-	7,624	(8,923)	406	808	27	**(58)**
Disposals other than for sale	-	(454)	-	(4,401)	-	-	**(4,855)**
Impairments/reversals charged to operating expenses		(2,804)					**(2,804)**
Impairments/reversals charged to reserves		(1,700)					**(1,700)**
Valuation/gross cost at 31 March 2017	**5,485**	**105,061**	**3,025**	**37,718**	**8,948**	**3,371**	**163,608**
Depreciation							
At 1 April 2016	**-**	**537**	**-**	**22,027**	**5,172**	**2,111**	**29,847**
Disposals other than for sale	-	(454)	-	(3,739)	-	-	**(4,193)**
Impairment/reversals charged to reserves		(3,076)					**(3,076)**
Impairments/reversals charged to operating expenses		(1,353)		14			**(1,339)**
Charged during the year	**-**	**4,451**	**-**	**2,783**	**958**	**281**	**8,473**
At 31 March 2017	**-**	**105**	**-**	**21,085**	**6,130**	**2,392**	**29,712**
Net book value at 31 March 2017	**5,485**	**104,956**	**3,025**	**16,633**	**2,818**	**979**	**133,896**
Asset financing:							
Owned - purchased	5,485	76,361	3,025	10,709	2,751	919	**99,250**
Finance leased	-	2,108	-	4,634	-	-	**6,742**
On-SoFP PFI contracts and other service concession arrangements	-	21,221	-	-	-	-	**21,221**
Owned - government granted	-	407	-	171	-	2	**580**
Owned - donated	-	4,859	-	1,119	67	58	**6,103**
Total at 31 March 2017	**5,485**	**104,956**	**3,025**	**16,633**	**2,818**	**979**	**133,896**

NOTES TO THE ACCOUNTS

8.3 Property, Plant and Equipment (Continued)

The Trust acquired £46k (2016/17 £498k) worth of equipment assets via Charitable Funds held by the Trust in 2017/18. Capital building/site works totalling £603k in 2017/18, funded by the Trust Charity, were also spent by the Trust on the Dementia Wards (2016/17 £694k), Brantham Ward, Cycle Parking and Mortuary Improvements. The Trust also received a grant of £250k from the County Air Ambulance HELP Appeal in 20178, via the Trust Charity – of which, £226k has been spent via Trust Capital as at 31st March 2018.

The Trust employed the services of Gerald Eve LLP, a firm of independent valuers, to undertake a revaluation of the Trust's land and property assets as at 31 March 2018. The valuation was undertaken in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards (sixth edition) insofar as these are consistent with the requirements of HM Treasury and the Department of Health.

As a result of the revaluation, a £0.163m gain in the value of Land and Buildings has been applied.

The substantial majority of buildings have been valued as specialised operational assets using the depreciated replacement cost approach on a modern equivalent asset basis. Land is valued on an existing use replacement value basis.

The valuation for operational assets was subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The gross carrying amount of fully depreciated assets still in use is £16.923m.

The minimum and maximum periods over which assets are depreciated are as follows

	Minimum	Maximum
Buildings exc Dwellings	1	76
Plant & Machinery	5	15
Information Technology	3	10
Furniture and Fittings	5	10

NOTES TO THE ACCOUNTS

9.1 Trade and Other Receivables

	Current		Non-Current	
	31 March 2018 £000	31 March 2017 £000	**31 March 2018 £000**	31 March 2017 £000
Current				
Trade receivables	8,976	11,536	-	-
Accrued income	13,987	12,432	-	-
Provision for impaired receivables	(1,356)	(2,930)	(256)	(251)
Prepayments (non-PFI)	3,211	4,975	-	-
PFI lifecycle prepayments*	-	-	1,864	-
PDC dividend receivable	15	95	-	-
VAT receivable	183	612	-	-
Other receivables	1,348	1,246	1,571	1,661
Total	**26,364**	27,966	**3,179**	1,410
Total current and non current	**29,543**	29,376		

* In the prior year, lifecycle prepayments were included within PFI obligations payable

The great majority of trade is with Clinical Commissioning Groups and NHS England. As both are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Receivables which are neither past their due date nor impaired are considered to be of acceptable credit quality.

9.2 Receivables past their due date but not impaired

	31 March 2018 £000s	31 March 2017 £000s
By up to three months	5,550	7,898
By three to six months	1,404	902
By more than six months	831	443
Total	**7,785**	9,243

Of the unimpaired receivables, £1,931k are non-NHS, of which £448k are more than 3 months past their due date.

NOTES TO THE ACCOUNTS

10 Cash and Cash Equivalents

	31 March 2018 £000	31 March 2017 £000
Opening Balance	**943**	879
Net change in year	413	64
Closing Balance	**1,356**	943
Made up of		
Cash with the Government Banking Service	1,352	939
Cash in hand	4	4
Cash and Cash Equivalents as in Statement of Financial Position	**1,356**	943
Cash and Cash Equivalents as in Statement of Cash Flows	**1,356**	943

11 Trade and Other Payables

	31 March 2018 £000	31 March 2017 £000
Trade payables	9,504	16,786
Accruals	16,840	17,177
Capital payables	407	453
Deferred Income	2,589	2,184
Social security costs	2,207	1,885
Accrued interest on loans	213	137
Tax	1,880	1,663
Payments received on account	46	33
Other	152	78
Total payables	**33,838**	40,396
Included above:		
Outstanding Pension Contributions at the year end	2,423	2,227

NOTES TO THE ACCOUNTS

12 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	17,324	-
Obligations under finance leases	898	671
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	829	800
Total current borrowings	**19,051**	1,471
Non-current		
Loans from the Department of Health and Social Care	51,440	48,802
Obligations under finance leases	5,347	5,111
Obligations under PFI, LIFT or other service concession contracts	20,609	19,953
Total non-current borrowings	**77,396**	73,866

13 Finance Lease Obligations (Trust as lessee)

The Trust has a variety of financial leases for equipment and demountable buildings. These leases do not include any clauses in respect of renewal, purchase or escalation and any such issues to be dealt with by negotiation at the end of the primary lease period.

No restrictions are placed on the Trust by the leases other than to return the assets in working condition at the end of the lease period.

	31 March Buildings £000	31 March Other £000	31 March Total £000	2017 Total £000
Gross lease liabilities	**1,169**	**6,547**	**7,716**	7,113
of which liabilities are due:				
Not later than one year;	146	1,109	1,255	953
Later than one year and not later than five years;	585	3,592	4,177	3,775
Later than five years.	438	1,846	2,284	2,385
Finance charges allocated to future periods	(250)	(1,221)	(1,471)	(1,331)
Net lease liabilities	**919**	**5,326**	**6,245**	5,782
of which payable:				
Not later than one year;	94	804	898	671
Later than one year and not later than five years;	432	2,837	3,269	2,987
Later than five years.	393	1,685	2,078	2,124

NOTES TO THE ACCOUNTS

14 Operating Leases

14.1 Operating Lease Income and future receipts (Trust as Lessor)

	31 March 2018 £000	31 March 2017 £000
Operating lease revenue		
Contingent rent	226	205
Total	**226**	205

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
Not later than one year;	144	127
Later than one year and not later than five years;	392	380
Later than five years.	1,927	2,016
Total	**2,463**	2,523

14.2 Operating Lease Payments and Commitments (Trust as Lessee)

	31 March 2018 £000	31 March 2017 £000
Operating lease expense		
Minimum lease payments	353	261
Total	**353**	261

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
Not later than one year;	2,008	539
Later than one year and not later than five years;	5,394	1,287
Later than five years.	1,601	244
Total	**9,003**	2,070

NOTES TO THE ACCOUNTS

15 Provisions

	Pensions - early departure costs £000	Legal claims £000	Other £000	Total £000
Balance a 1 April 2017	**224**	**65**	**1,316**	**1,605**
Change in the discount rate	1	0	8	**9**
Arising during the year	9	34	197	**240**
Utilised during the year	(49)	(55)	(468)	**(572)**
Unwinding of discount	-	-	2	**2**
Balance at 31 March 2018	**185**	**44**	**1,055**	**1,284**
Expected timing of cash flows:				
Not later than one year;	39	10	246	**295**
Later than one year and not later than five years;	109	-	243	**352**
Later than five years.	37	34	566	**637**
Total	**185**	**44**	**1,055**	**1,284**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000
As at 31 March 2018	**221,142**
As at 31 March 2017	211,241

The value and expected timings of the public and employers liability (legal claims) and injury benefit provisions (other) are calculated by reference to information, available at the reporting date, provided by the Trust's legal advisors. As new evidence comes to light, the value of the provision can change either up to down. Similarly, new evidence can affect the expected timing of the cash flows.

The provision for early departure costs represents the actuarial liability for staff who took early retirement before 6 March 1995. This is settled by a quarterly charge from the NHS Pensions Agency.

NOTES TO THE ACCOUNTS

16 PFI and LIFT - additional information

The Trust has no LIFT contracts

The Trust has no off SOFP PFI contracts

Charges to operating expenditure and future commitments in respect of ON SOFP PFI

	2017/18 £000	2016/17 £000
Service element of on SOFP PFI charged to operating expenses in year	815	806
Total	**815**	806

Payments committed to in respect of the service element of on SOFP PFI

No Later than One Year	823	791
Later than One Year, No Later than Five Years	3,292	3,164
Later than Five Years	10,700	11,074
Total	**14,815**	15,029

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2017/18 £000	2016/17 £000
Not later than one year;	1,597	1,597
Later than one year and not later than five years;	7,293	7,067
Later than five years.	20,549	20,887
Subtotal	**29,439**	29,551
Less: Interest Element	(8,001)	(8,798)
Total	**21,438**	20,753

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	2017/18 £000	2016/17 £000
Not later than one year;	829	800
Later than one year and not later than five years;	4,576	4,200
Later than five years.	16,033	15,753
	21,438	20,753

Number of on SOFP PFI Contracts

Total Number of on SOFP PFI contracts	**1**

The Trust has a PFI agreement in place with Prospect Healthcare Limited in respect of the Garrett Anderson Centre, a building that houses the Trust's Accident & Emergency Unit, Intensive Care Unit, Day Surgery Unit and a 40 bedded Ward. This fixed 30 year term agreement covers the design, build and maintenance of the building to a set standard for the duration of the contract at the end of which the building will revert to the Trust's freehold ownership.

Prospect Healthcare Limited receive a single unitary payment to cover all the elements of the facility that they are contracted to provide. This unitary payment was fixed at the start of the contract and its value is indexed on an annual basis using a pre-specified agreed National Index. Any variations to the contract in terms of changes to the specification of the building go through a formal change control process with a clearly specified methodology for calculation of the financial impact, both in the current period and over the remaining life of the contract.

Failure to provide the accommodation in terms of availability and quality results in a reduction in the unitary payment until the failure is rectified.

The contract for the agreement commenced on 28 March 2006 and is for a period of 30 years. The estimated capital value of the scheme at inception was £29.084 million.

NOTES TO THE ACCOUNTS

17 Financial Instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with CCGs and NHS England and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its Capital Resourse Limit. The Trust is not, therefore, exposed to significant liquidity risks.

17.2 Financial Assets

	Loans and receivables £000	Total £000
Trade and other receivables excluding non financial assets	24,269	**24,269**
Cash and cash equivalents at bank and in hand	1,356	**1,356**
Total at 31 March 2018	**25,625**	**25,625**

	Loans and receivables £000	Total £000
Trade and other receivables excluding non financial assets	23,693	**23,693**
Cash and cash equivalents at bank and in hand	943	**943**
Total at 31 March 2017	**24,636**	**24,636**

NOTES TO THE ACCOUNTS

17 Financial Instruments (continued)

17.3 Financial Liabilities

	Other financial liabilities £000	Total £000
Borrowings excluding finance lease and PFI liabilities	68,764	**68,764**
Obligations under finance leases	6,245	**6,245**
Obligations under PFI, LIFT and other service concession contracts	21,438	**21,438**
Trade and other payables excluding non financial liabilities	27,117	**27,117**
Total at 31 March 2018	**123,564**	**123,564**

	Other financial liabilities £000	Total £000
Borrowings excluding finance lease and PFI liabilities	48,802	**48,802**
Obligations under finance leases	5,782	**5,782**
Obligations under PFI, LIFT and other service concession contracts	20,753	**20,753**
Trade and other payables excluding non financial liabilities	34,631	**34,631**
Total at 31 March 2017	**109,968**	**109,968**

	31 March 2018 £000	31 March 2017 £000
In one year or less	48,032	36,102
In more than one year but not more than two years	33,514	18,854
In more than two years but not more than five years	25,771	37,135
In more than five years	16,247	17,877
Total	**123,564**	109,968

NOTES TO THE ACCOUNTS

18 Events after the end of the reporting period

There were no events after the the end of the reporting period.

19 Related Party Transactions

During the year none of the Department of Health Ministers, Ipswich Hospital NHS Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party, and parent Department of Ipswich Hospital NHS Trust. During the year Ipswich Hospital NHS Trust had material transactions with the Department, and with other entities for which the Department of Health is regarded as the parent Department. The Trust considers material transactions to include those individually or in aggregate exceeding £100,000. The entities which the Trust had material transactions during the year are as follows.

CCGs
NHS Cambridgeshire and Peterborough CCG
NHS Great Yarmouth and Waveney CCG
NHS Ipswich and East Suffolk CCG
NHS Mid Essex CCG
NHS North East Essex CCG
NHS South Norfolk CCG
NHS West Suffolk CCG

NHS Foundation Trusts
Cambridge University Hospitals NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Oxford Health NHS Foundation Trust
Royal Papworth Hospital NHS Foundation Trust
West Suffolk NHS Foundation Trust

NHS Trusts
Cambridgeshire Community Services NHS Trust
East of England Ambulance Service NHS Trust
St Helens and Knowsley Hospital Services NHS Trust

NHS England Bodies
NHS England - Core
NHS England - East Local Office
NHS England - South Central Local Office
NHS England - East Midlands Specialised Commissioning Hub
NHS England - East of England Specialised Commissioning Hub

Other Bodies
Public Health England
Health Education England
NHS Resolution (formerly NHS Litigation Authority)
Care Quality Commission
NHS Property Services
Department of Health and Social Care
NHS Blood and Transplant
Suffolk County Council

Various departments within the Trust also received revenue and capital payments from a number of Charitable Funds for which the Trust is the Corporate Trustee. These payments amounted to £1,383k (2016/17 £1,530k). The Trust provides administrative and management services to the Charitable Funds for which a charge of £72k (2016/17 £54k) (reflecting actual costs) has been made for the 2017/18 financial year. At 31 March 2018 the Charitable Funds owed £198k (31 March 2017: £68k) to the Trust.

NOTES TO THE ACCOUNTS

20 Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

20.1 Breakeven performance

	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	3,351	1,260	137	205	50	(11,893)	(22,098)	(17,578)	(13,432)
Breakeven duty cumulative position	(5,005)	(3,745)	(3,608)	(3,403)	(3,353)	(15,246)	(37,344)	(54,922)	(68,354)
Operating income	225,962	235,136	238,150	236,732	249,439	250,597	266,310	296,451	321,629
Cumulative breakeven position as a percentage of operating income	-2.21%	-1.59%	-1.52%	-1.44%	-1.34%	-6.08%	-14.02%	-18.53%	-21.25%

NOTES TO THE ACCOUNTS

20.2 Capital Cost Absorption Rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

20.3 External Financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2017/18	2016/17
	£000	£000
External financing limit (EFL)	21,921	29,303
Cash flow financing	19,515	28,295
Finance leases taken out in year	1,687	712
External financing requirement	**21,202**	29,007
Under spend against EFL	**719**	296

20.4 Capital Resource Limit

	2017/18	2016/17
	£000	£000
Gross capital expenditure	12,683	11,805
Less: Disposals	-	(662)
Less: Donated and granted capital additions	(875)	(2,934)
Charge against Capital Resource Limit	**11,808**	8,209
Capital Resource Limit	**11,903**	8,274
Under spend against CRL	**95**	65

NHS
The Ipswich Hospital
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Find out more about the hospital by visiting our website at www.ipswichhospital.nhs.uk or find us on Twitter: @IpswichHosp

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This Trust is working towards equal opportunities.

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