The Ipswich Hospital NHS
NHS Trust

The Ipswich Hospital NHS Trust

Annual Report and Accounts 2018/ 2019

Quarter one

Welcome

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.

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 the Ipswich Star, East Anglian Daily Times, BBC Radio Suffolk, Heart FM, Town 102, BBC Look East, ITV Anglia
- Health colleagues across the East of England

This report was compiled by the trust's communications team. Photography is by our communications team, in-house clinical photography team and freelance photographers.

Contents

This Annual Report for quarter one has been prepared in accordance with the requirements set out in the Department of Health Group Manual for Accounts 2018/19.

Quality Accounts are prepared for a 12-month period. Therefore as The Ipswich Hospital NHS Trust demised on 01 July 2019, it is not required to prepare a Quality Account. As part of the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust, a programme of due diligence was carried out which included quality governance. This was independently reviewed to give assurance to the successor organisation on the quality of The Ipswich Hospital NHS Trust's services.

Performance Report

Overview

Chair's foreword

The first three months of 2018/19 have been some of the most significant in The Ipswich Hospital NHS Trust's history. As well as continuing our focus on providing high standards of care, we have been preparing to merge with Colchester Hospital University NHS Foundation Trust in a move which will see us form the largest NHS trust in East Anglia.

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 brightest staff to the region. It will also enable us to really focus on our philosophy of Time Matters so that we can remove or improve the things we do which cause unnecessary stress or frustration for our patients, families and carers and our staff. We are confident that this exciting merger will bring real benefits for thousands of people every year.

During the first quarter of 2018/19, we continued to work closely with our health and care partners to join up services for the benefit of local people. We also made improvements to the Heath Road site, including our new helipad which will make it quicker and easier for staff to transfer critically ill patients into our Emergency Department. Throughout the rest of the year, we will continue to make changes to improve the environment in which our patients receive care so that we can ensure they have the best possible experience when coming to Ipswich Hospital and our community services.

Our two major charity appeals – the Blossom Appeal, which is raising money towards a £2.5m breast care centre, and the Children's Appeal, which aims to completely reconfigure our children's facilities – have continued to attract fantastic support from local people. We are truly grateful to everyone who so generously gives their time to help raise funds for our hospital, and whose dedication continues to make a real difference to our patients.

Finally, I would like to pass on my thanks to our staff and volunteers who have worked so hard to care for and support our patients this year. I look forward to continuing to work closely with you all during the rest of the year as we embark on the next exciting chapter in our Trust's history.

David White
Chairman

Chief Executive's overview

The first quarter of this year has provided a time for reflection as we prepare not only for The Ipswich Hospital NHS Trust's merger with Colchester Hospital University NHS Foundation Trust, but also to celebrate the 70th birthday of the NHS on 5 July.

I have always been incredibly proud to work in the health service, and proud of the dedicated and compassionate care which our staff provide to the 3,500 people who rely on our services every single day. However, it is clear that the NHS continues to face challenges caused by increases in demand, finance and workforce issues. We need to find ways to do things differently to make our NHS sustainable, and one of those is by working more closely together. The creation of East Suffolk and North Essex NHS Foundation Trust on 1 July offers us a fantastic opportunity to do just that, while also driving through real improvements on behalf of our patients.

This integration is being mirrored in our ongoing Sustainability Transformation Partnership work, which has brought together health and social care, statutory and third sector providers across Suffolk and north east Essex. I look forward to continuing to work closely with these partners over the remainder of the year to help us all deliver our shared ambition to improve the services we provide and the health of local people.

Nick Hulme
Chief Executive

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 NHS Trust is recognised by our patients and peers as a provider of good quality healthcare with a reputation for delivering caring and compassionate services.

Every day, around 3,500 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. We also have responsibility for community hospitals in Felixstowe, Aldeburgh and at Bluebird Lodge in Ipswich, as well as some community services.

We have a catchment population of approximately 390,000 people, primarily drawn from the districts of Babergh, Mid Suffolk, Suffolk Coastal and Ipswich. 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.

Our 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.

The Trust has more than 550 beds in general acute, maternity, paediatric and neonatal services. Across our 46-acre site and community services, we employ 3,500 whole time equivalent NHS staff.

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 our central outpatient reception and waiting area.

Our future plans

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. 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.

On 1 July 2018, we are due to merge with Colchester Hospital University NHS Foundation Trust, with a change of name to East Suffolk and North Essex NHS Foundation Trust (ESNEFT). The merger will make sure patients are seen at the right time while attracting and retaining the best staff and providing the latest treatments locally. The organisation will be the largest NHS trust in the region, which will give us the scale to save, strengthen and grow some services. The hospital 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 as well as our community services.

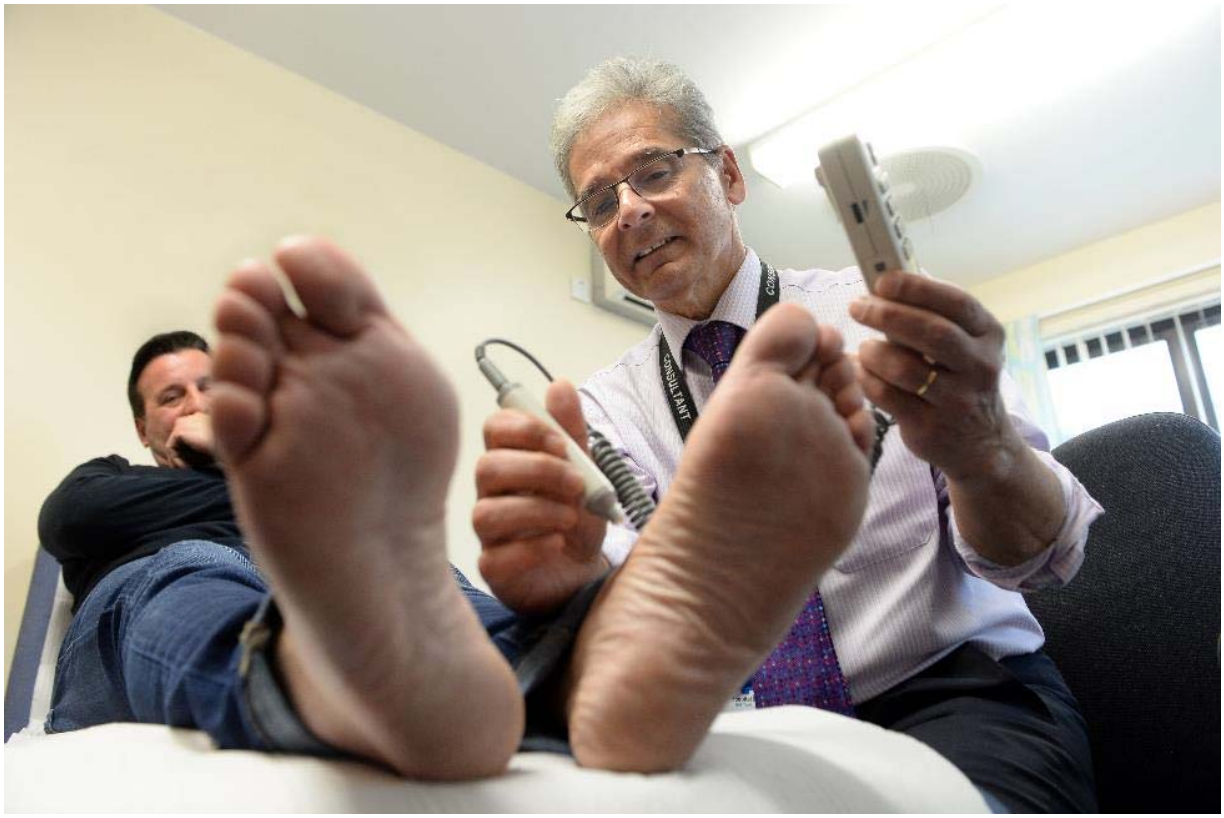
Merging will also save patients journeys further afield to hospitals in London, Cambridge, Norfolk or Basildon, in turn ensuring they can get the high quality care they need closer to home.

Trust objectives

Vision, goals and strategic objectives on a page

Vision	**To be an outstanding provider of health services for our population**			
Values	**Respect Kindness Listen and 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 • 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 or 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 • Be proud of the care we provide • Empower staff to take personal responsibility every day
Primary key performance indicators (KPIs)	• Provide increased community-	• 60% reduction in outpatient	• Top 10% for efficiency,	• Top 25% for communication

	based care to constrain emergency admissions to 2016/17 levels • 25% reduction in the number of people dying in hospital	follow ups without a decline in outcomes • All residential/ nursing homes to be supported by technology, training, education and collaboration	as measured by Carter • 13% reduction in agency expenditure from 2016/17 baseline	from management • Top 25% for training and appraisal satisfaction



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 • Three-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
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 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

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 other topic specific agenda's.
- 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.

Quality improvement priorities for 2018/19

Priority	Target	Key measure
Patient safety priority: To improve compliance with the Sepsis Six care bundle.	• Commence treatment of sepsis according to Sepsis Six pathway; complete all within 60 mins = 90% • To increase the number of clinical staff having received sepsis training: o Q1 = 50% of clinical staff trained o Q2 = 75% of clinical staff trained o Q3 = 80% of clinical staff trained o Q4 = maintain 80% of clinical staff trained	• Audit timely identification and treatment of sepsis. • Monitor compliance with staff training for doctors, registered nurses and healthcare assistants. • Compliance with CQUIN for identification and treatment of suspected sepsis.
Clinical effectiveness priority: To improve access to psychiatric liaison services for hospital inpatients.	• To meet the 95% target for patients attending ED needing psychiatric intervention (review within one hour). • To provide patients with access to mental health review during their admission in the acute hospital (review within same day or 24 hours).	• Review and regular monitoring of KPIs. • Development of a dashboard to capture and collate information and performance.
Patient experience priority: 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. • Surveys of bereaved relatives.

		• Service assessment reviews of new initiatives. • Review of processes and policy for end of life care.
Patient experience priority: Work with all clinical partners to identify the most appropriate service for children and young people needing unplanned medical advice or care. This is the second year of a two-year priority.	• To reduce the number of under 18s attending ED by 5% by 2022, against a growing population.	• Monitor the number of attendances in ED and admissions from ED by children and young people. • Review of audit data to shape key priorities.

In anticipation of the merger the trust worked collaboratively with Colchester Hospital University NHS Foundation Trust to set the quality priorities to ensure continuity into the new organisation.

Accountability

The Trust has an Accountability Framework 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 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 Accountability Framework oversight meetings or other stated forum;
- Further reviews as needed; and
- 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.

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 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 Sustainability and Transformation Partnership 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.

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.

- Rapid screening clinics in dermatology – the consultant purely focusses 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.

A demand management rollout programme has been agreed by the Sustainability and Transformation Partnership, 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.

Performance analysis

Performance against key indicators

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

Key facts and figures for quarter one:

Births	908
Emergency Department attendances	21,648 excluding the Minor Injuries Unit 24,860 including the Minor Injuries Unit
Planned admissions	1,623 excluding day cases 13,493 including day cases
Unplanned admissions	10,155 including maternity 8,445 excluding maternity
Outpatient attendances (includes an increase in community activity)	290,215
Number of appointments people did not attend	10,823
Diagnostic imaging examinations (2017 calendar)	63,589
Referrals from GPs and dentists	29,272

Key performance indicators (KPIs)

Indicator	Subsections	Target	Q1
From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 week	92%	Yes
All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	Yes
	Drugs	98%	Yes
	Radiotherapy	94%	Yes
All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	No
	From NHS Cancer Screening Service referral	90%	Yes
All cancers: 31-day wait from diagnosis to first treatment		96%	Yes
Cancer: Two-week wait from referral to date first seen, comprising:	All urgent referrals	93%	Yes
	For symptomatic breast patients (cancer not initially suspected)	93%	No
A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	No
Clostridium difficile	Is the Trust below the YTD ceiling	6	No
MRSA	Is the Trust below the YTD ceiling	0	Yes

Operating financial review

For the first quarter of 2018/19, and before financial adjustments related to the merger ('transfers by absorption'), the Trust incurred a deficit of £6.8m against a plan of £6.3m. This included £0.8m of support from the Provider Sustainability Fund, which was set up in 2017/18 by NHS Improvement to support providers to move to a sustainable financial footing based on their financial and operational performance.

After financial adjustments related to the merger, the Trust is reporting a deficit for the year of £48.1m. This incorporates £41.4m of loss arising from the transfer by absorption to ESNEFT. The value of this transfer represents the value of the net assets and liabilities transferred from Ipswich Hospital at the date of merger.

After asset revaluation gains are taken into account, the Trust's total comprehensive expense for the year is £46.8m.

	2018/19 Q1 £m	2017/18 £m
Operating income	80.4	321.6
Operating costs	(83.7)	(319.9)
EBITDA*	**(3.3)**	**1.7**
Non-operating costs	(3.5)	(13.8)
Surplus/(deficit) for the year BEFORE loss arising from transfers by absorption	**(6.8)**	**(12.1)**
Loss arising from transfers by absorption	(41.4)	n/a
Retained deficit for the financial year	**(48.1)**	**(12.1)**
Impairments and other revaluation reserve movements	1.3	(0.5)
Total comprehensive expense for the year	**(46.8)**	**(12.6)**

*EBITDA is Earnings Before Interest, Taxation, Depreciation and Amortisation

From 1 July 2018 the assets, liabilities and ongoing operational income and expenditure of the Trust form part of the ESNEFT accounts.

Going concern

The financial statements have been prepared on a going concern basis. After taking into account all relevant factors, the Board has determined that the accounts should be prepared on a going concern basis for the period ended 30 June 2018 based on the following factors:

In June 2018, NHS Improvement approved the acquisition of the Trust by Colchester Hospital University NHS Foundation Trust and for the combined organisation to be subsequently known as East Suffolk and North Essex NHS Foundation Trust. Following that decision, the Board had

a clear and fixed intention for the acquisition to proceed on 1 July 2018 and that there was no reason to believe that this would not be achieved.

The Trust had submitted a joint financial plan for the remainder of the financial year to the end of March 2019 and main commissioners had supported the acquisition proposal and the continuation of previously agreed contracts, all of which had been signed as at 31 March 2018.

As directed by the GAM 2018/19, 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. In that respect, all of the services provided previously by The Ipswich Hospital NHS Trust have now been taken on and are being provided by East Suffolk and North Essex NHS Foundation Trust, and these services will continue to be delivered using the same assets as acquired from the Trust.

Our buildings and structure

During the first quarter of 2018/19, the estates and facilities capital development team delivered several important projects at the hospital, including:

Our new hospital helipad

A new lifesaving helipad which is making it much faster to transfer seriously ill patients into hospital welcomed its first air ambulance in June.

The landing pad has been created next to our Emergency Department and replaces our old helipad, which was at the back of Copleston High School.

As well as giving patients the best chance of survival by allowing staff to get them into the department more quickly, it is also making it easier for our Trust and air ambulance teams to transfer patients from Ipswich Hospital for emergency treatment in other specialist centres.

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 having to travel to hospitals further afield.

The upgrade was made possible 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.

£100,00 mortuary upgrade

A new-look family area, visitors' room and garden opened in our mortuary during May 2018 to provide relatives with a calm and reflective space in which to say goodbye.

The £100,000 upgrade, which was funded by the Ipswich Hospital Charity, saw the public areas made brighter and more welcoming, while doorways were widened and a new disabled toilet installed to make the mortuary fully accessible to people using wheelchairs. New artwork was also added and the staff room refurbished, while the outside area was completely transformed with new planting and a patio.

The new-look mortuary, which has been named the Rosemary Suite, is designed to give relatives a more welcoming environment in which to spend time with loved ones they have lost.

Sustainability

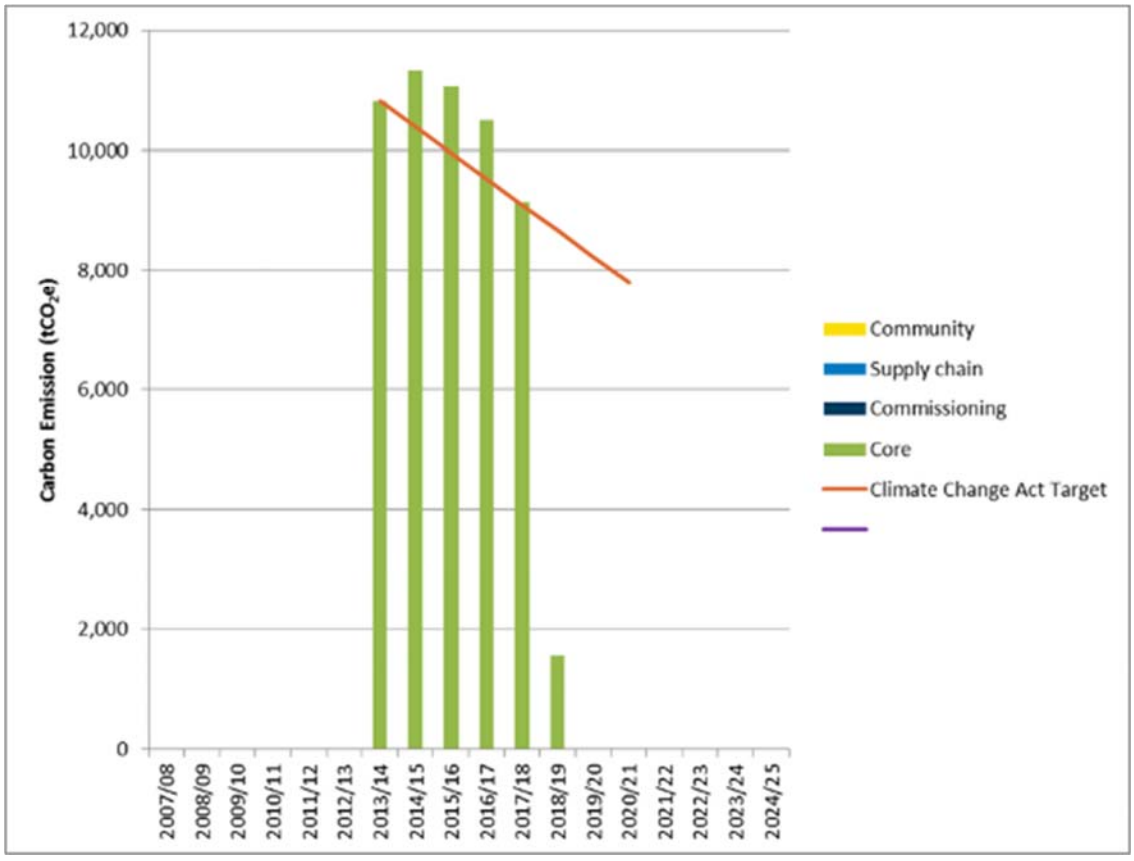
Leadership and engagement

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

During the first quarter of 2018/19, work began on bringing our overall sustainability agenda up-to-date to reflect the partnership with Colchester Hospital University NHS Foundation Trust. Our Sustainable Development Management Plan will also be adapted to suit East Suffolk and North Essex Foundation Trust during the coming 12 months.

Resources

Energy and water (year to date)



Energy emissions decreased again in the first quarter of 2018/19, keeping the Trust on track to surpass the 2020 target.

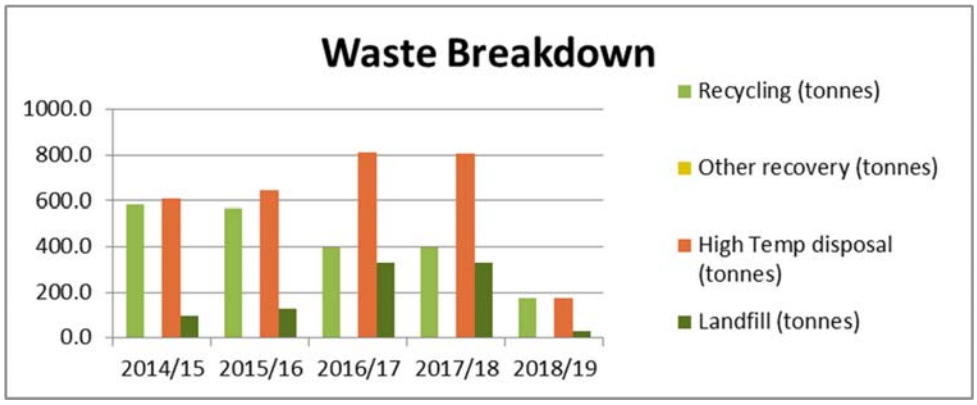
Water consumption has increased slightly, with current figures at 26% of last year's consumption. However, this figure extrapolates out at 144,404m³.

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 a year.

Waste

Our total waste production for quarter one is in line with 2018/19, whilst recycling has further increased on the previous year. The Trust has sent 46% of its waste for recycling and 46% for incineration, which is subsequently used to produce steam and hot water. The remaining 8% goes to landfill.



Travel

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

Procurement

During the first quarter of 2018/19, the estates and facilities department have worked closely with hotel services partner OCS to introduce a number of sustainability initiatives, including:

- An 'on demand' food ordering system, which means patients will be able to order meals up to an hour before meal times, avoiding wasted meals.

- Giving staff the chance to order and pay for meals online so that they can collect their food more quickly and increase the amount of time they spend resting, in turn improving wellbeing.
- Increasing the choice of food offered out-of-hours, again improving the wellbeing of our staff and visitors.
- Increasing the number of staff working in our car parks to help patients and staff with parking and travel.

Fire safety

Fire safety continues apace. The new organisational structure, following the merger to form ESNEFT, requires a fire safety officer at each site. Therefore particular emphasis has been placed on the handover of fire-related duties at Ipswich Hospital from Malcolm Hawken to Chris Cage during the first quarter of the year. From 1 May onwards, all staff fire training at the Ipswich Hospital site has been carried out by Chris Cage, with various training packages updated as a result.

During the first quarter, 16 fire risk assessments have been carried out. There have also been three site visits by operational crew from Suffolk Fire and Rescue Service (SFRS) and an additional annual information gathering visit by SFRS's risk and resilience officers. The Trust's working relationship with SFRS continues to be good and their operational staff are encouraged to visit the site and familiarise themselves with it as often as necessary.

Later in the year, a full evacuation drill involving live 'patients' from the sixth floor of the maternity block will take place. Considerable pre-planning has already been carried out to help the Trust prepare for this, while our intention is to involve operational staff from SFRS in testing our evacuation strategy.

Security

During the first quarter, we have continued with the upgrade of the CCTV recording system by adding new high definition cameras and improving our monitoring abilities. The upgraded CCTV systems have increased the hospital's ability to monitor and have led to an increase in the successful identification of crimes. In addition, we have continued to support Suffolk Constabulary on numerous occasions, including providing vital CCTV evidence to support criminal investigations and prosecutions.

We have updated our conflict resolution and breakaway technique training in line with lessons learnt through feedback we have received and incidents which have taken place, and now have a dedicated inhouse trainer. Statistics show that 266 members of staff have attended the conflict resolution training refresher and 34 members of staff have attended the disengagement techniques course.

All new staff joining the Trust now receive a security brief based on 10 key fundamental security areas as part of their induction. A total of 256 members of staff have attended these sessions so far.

The total number of reported assaults on staff during between April and June 2018 are 30, with 20 incidents of verbal abusive and aggressive nature. Where appropriate, these incidents were reported to the police and the appropriate action was taken which, in some cases, results in prosecution of 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 occurrences.

The increase in security awareness has led to a significant reduction in reports of thefts across the Trust from 15 in 2017 to five last year. We have established a Security Management Group which meets regularly to oversee the security work streams and has a multidisciplinary attendance list to ensure the correct level of scrutiny and involvement is in place.

Our focus on the security of people and assets within the Trust will continue to ensure that the risks associated with security issues can be addressed at an appropriate level.

Emergency planning

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 CHUFT in sharing an emergency planning lead across two sites.

During the reporting period, we have participated in and held exercises testing our response to various scenarios, both alone and in conjunction with system partners. These exercises have shown our plans to be largely suitable to respond to the scenarios tests and we have amended and updated plans where we have identified that improvements were needed.

Accountability Report

Corporate Governance Report

Directors' report

Composition of the Board

The overall management of the trust 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 Director of Finance and Performance usually attends 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.

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 & Development, Remuneration and Terms of Service and Charitable Funds. Details of Directors' remuneration are given in the remuneration report, which begins on page 56.

Chair and Non-Executives – at 30 June 2018	
David White	Chair
Tony Thomson	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

Composition of the management Board

We place clinicians at the centre of the trust's leadership. There are three operational 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 30 June 2018	
Nick Hulme	Chief Executive
Neill Moloney	Managing Director
Dr Crawford Jamieson	Medical Director
Claire Thompson	Director of Nursing (Acting)
Simon Rudkins	Acting Director of Finance and Performance
Clare Edmondson	Director of HR
Denver Greenhalgh	Director of Governance
Simon Hallion	Director of Operations
Paul Fenton	Director of Estates
Mike Meers	Director of Information Communications and Technology
Alison Smith	Director of Community Services
Ali Bailey	Director of Communications

Declaration of interests 1 April 2018 to 30 June 2018

Ann Alderton Company Secretary	• Company Secretary – Colchester Hospital University NHS Foundation Trust • Husband is manager at West Suffolk NHS Foundation Trust • Shareholder and Managing Director – Tredaran Consulting Ltd
Ali Bailey (from 1 May 2017) Director of Communications	• Nil
Laurence Collins Non-Executive Director	• Governor of Rushmere Hall Primary School, Ipswich • Member of Two Rivers Medical Centre PPG
Clare Edmondson Director of Human Resources	• Nil
Paul Fenton (from 1 January 2018) Director of Estates	• Immediate past Chairman of HefmA Company Ltd • 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 (from 12 April 2017) Director of Operations	• Nil
Nick Hulme Chief Executive	• CEO at Colchester Hospital University NHS Foundation Trust • STP system lead
Dr Crawford Jamieson (from 1 August 2017) Medical Director	• West Suffolk CCG secondary care lead (until 1 August 2017) • Wife in 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 (to 31 July 2017) Interim Medical Director	• Nil
Mike Meers (from 1 September 2017) Director of ICT	• Director of ICT at Colchester Hospital University NHS Foundation Trust
Neill Moloney Managing Director	• Managing Director at Colchester Hospital University NHS Foundation Trust
Claire Thompson (from 19 March 2018) Director of Nursing	• Spouse MD of Vyaire Medical International (healthcare consumables company)
Elaine Noske Non-Executive Director	• Paid employee BT
Simon Rudkins (from 30 September 2017) Director of Finance	• Nil
Paul Scott (to 1 October 2017) Director of Finance and Performance	• Nil
Alison Smith (from 25 September 2017) Director of Community Services	• Nil
Helen Taylor Non-Executive Director	• Independent Chair of Waltham Forest Safeguarding Adults Board • Deben Associates Ltd
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

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.

We have well developed policies for research, development and intellectual property which places us in an excellent position to take part in national and international clinical research studies and to develop and implement innovations to improve the quality of care provided to our patients.

The research and development and innovation teams are always available to provide support to staff wishing to take part in research and to help develop ideas.

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 trust 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.

We aim to respond to complaints within 28 working days from receiving the complaint. In the first quarter of 2018/19, we responded to 89% of complaints within 28 working days or agreed a revised timescale 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 the first quarter of 2018/19, the top three subjects for complaints were aspects of care, treatment and poor communication.

Reopened complaints

During quarter one, 12 (7%) of 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 reopened 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 quarter one, four cases were investigated by the Ombudsman as the complainant was unhappy with the response received from the Trust. Of these, one was closed without further investigation, while the other three cases are still being investigated by the PHSO.

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.

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 service areas, 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 first quarter of 2018/19 were as follows:

	Positive	Neutral	Negative	Thanks	Total
Care Opinion	3	1	1	0	5
Healthwatch	33	5	7	0	45
NHS Choices	28	0	3	0	31
Website	0	0	0	0	0
Other	22	0	1	0	23
Your Views Matter	43	0	0	4	47
Compliment letters	36	0	0	0	36
Twitter	64	0	13	0	77
Facebook	4	0	2	0	6
Gratuities	787	0	0	0	787

Some examples of the comments we received include:

- **April 2018**: “In the last week I found myself in the unfortunate position of having to attend the hospital as a patient, first in A&E and the next day at the Fracture Clinic. I would like it to go on record that in both locations I was received with great kindness and sympathy, was effectively and efficiently looked after and treated like someone who mattered.”

- **April 2018:** Patient left telephone message to say how impressed she was with the staff in Endoscopy. They made her feel at ease even though the procedure was uncomfortable. She thought all the staff were great.

- **May 2018:** “In Stowupland Ward I was impressed with the diligent calm industry of the nurses, nursing assistants and auxiliaries. I noted too how they all worked well as teams. They were compassionate and competent, not just to me but other patients.”

- **June 2018**: “I was so impressed with the treatment I received in various different departments. I eventually was placed in Stradbroke Ward where everyone was very friendly and helpful.”

PALS

The PALS team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. They offer 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:

- service area concerns such as pain management or discharge arrangements
- patients chasing clinic or surgery appointments
- lost property
- car parking concerns
- resolving matters where patients are unable to contact the department of their choice by telephone

During quarter one, our PALS team dealt with 572 queries, compared with 544 for the first quarter of 2017/18.

Serious incidents requiring investigation (SIRIs)

In the first quarter of 2018/19, the Trust recorded 38 incidents which were reported as SIRIs on the national Strategic Executive Information System:

	Number of SIRIs
Delay in treatment	3
Developed grade three pressure ulcer	18
Diagnostic incident meeting SI criteria	2
Slip/trip/fall meeting SI criteria	5
Incorrect implant (never event)	1
Medication incident	3
Safeguarding incident	1
Maternity incidents meeting SI criteria	2
Sub-optimal care	2
Surgical invasive procedure meeting SI criteria	1

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 patients 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.

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 are carrying out face-to-face training for incidents, serious incidents and Duty of Candour
- We are carrying out root cause analysis training for serious incidents
- We have introduced the Trust's 'License to Lead' programme and a 'managing governance' module
- We have reviewed the way we share information about serious incidents and lessons learned within the area affected and wider as a Trust.

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 2018/19, 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.

Regrettably there was one never event during the first quarter of 2018 /19 involving an incorrect implant.

Safety 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 trust 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.

Statement of Directors' Responsibilities

Directors' statement of disclosure to auditors

The Directors at The 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 respect 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 the 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, 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 judgments and estimates which are reasonable and prudent; and
- 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.

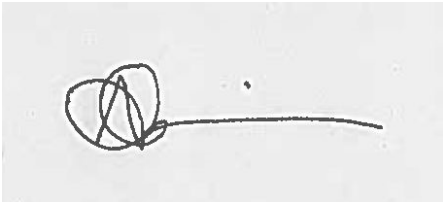
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

The Ipswich Hospital NHS Trust Annual Report and Accounts – quarter one 2018/19

By order of the Board

Nick Hulme
Chief Executive



Dawn Scrafield
Director of Finance

pp Mr Andrew Lehain, Deputy Director of Finance

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 has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of NHS Improvement.

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 with the approval of the Treasury 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. I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Accountable Officer: Nick Hulme

Organisation: The Ipswich Hospital NHS Trust

Signature:

Governance statement

Scope of responsibility

The Annual Governance Statement below only accounts for months one to three of the 2018/19 financial year as it relates to The Ipswich Hospital NHS Trust. The Trust was acquired by Colchester Hospital University NHS Foundation Trust (CHUFT) on 1 July 2018, thereby creating East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

As Accountable Officer, I have responsibility for maintaining a sound system of internal control which 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 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 Trust for the part-year ended 30 June 2018 and has been superseded by the ESNEFT system of internal control as at the date of approval of the annual report and accounts. This statement relates only to The Ipswich Hospital NHS Trust system of internal control.

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 to their role and responsibilities. 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 such as health and 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 made up 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. Seven 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 and one Non-Executive Director without voting rights also attended. The Chair has a second and casting vote. The Company Secretary also attended all Board meetings. The Deputy Chair acted as Senior Independent Director.

The Board met once in public in Q1 2018/19 with private Boards in the other two months. A Fit and Proper Persons check was carried out on all Board members and independently reviewed by the CQC as part of its 2017 inspection. The CQC concluded that “the Trust had a comprehensive Fit and Proper Persons Requirement 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”. As there were no changes to the Board after the CQC reached its conclusions, the next review of Fit and Proper Persons compliance will be for the ESNEFT Board. The Board’s Register of Interests was updated and presented at the May 2018 meeting.

There are six committees of the Board all of which report to the Board through the 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 draw 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 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 to report on standing items such as the review of risk and also as requested on exceptional items.

The Audit Committee met twice during Q1 2018/19 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.

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 and Effectiveness, Patient and Carer Experience and Trust Safety) and reports from safety and quality leads.

The Chair of the Quality Committee, a Non-Executive Director, reports key issues to the Trust Board after each meeting, and has raised any issues relating to internal control systems with the Audit Committee.

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 once during Q1 2018/19 in order to approve the merger of the Ipswich Hospital charity with the Colchester Hospital Charity.

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.

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

Transaction Governance

In addition to the above standing committees, the board met regularly during Q1 2018/19 with the board of Colchester Hospital University NHS Foundation Trust (CHUFT) in Board to Board meetings in order to confirm the acquisition by CHUFT of the Ipswich Hospital NHS Trust in order to create East Suffolk and North Essex NHS Foundation Trust. This forum was also supported by a Partnership Advisory Board, which oversaw risks relating to the transaction and programme delivery.

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 CHUFT as part of an agreed S106 undertaking between CHUFT and NHS Improvement (NHSI).

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

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. This was updated after the period covered by this statement in order to reflect arrangements in place for East Suffolk and North Essex NHS Foundation Trust as the successor organisation to The Ipswich Hospital NHS Trust.

Executive oversight of risk framework

During Q1 2018/19, the day to day management of the Trust was managed by four clinical divisions. Each division had 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 mirrored the composition of the Trust Board. They were 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 continued to empower and embed the division accountability structures during this period and into the period of the merger. 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 continued 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 was undertaken monthly at the Risk Oversight Committee which had executive members and non-executive director attendance. The divisional leaderships and the executive directors met monthly as an Executive Management Committee, which was responsible for ensuring the risks on the corporate risk register and Board Assurance Framework are managed. The committee submitted 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. 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 Q1 2018/19. This involved a wrong implant being given to a patient. The patient waiting list theatre schedule was correctly completed, but the individual

patient sheet was incorrectly completed during the pre-assessment appointment. The WHO checklist was completed correctly. 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 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

Quality Accounts are prepared for a 12-month period. Therefore as The Ipswich Hospital NHS Trust demised on 01 July 2019, it is not required to prepare a Quality Account. As part of the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust, a programme of due diligence was carried out which included quality governance. This was independently reviewed to give assurance to the successor organisation on the quality of The Ipswich Hospital NHS Trust's services.

In preparation for the merger the Trust has work with and aligned its quality priorities with those of Colchester Hospital University NHS Foundation Trust to enable continue of improvement programmes in 2018/19.

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. This 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.

Developing Workforce Safeguards
(The above recommendations did not come into effect until October 2018

The Developing Workforces Safeguards were published in October 2018 and was therefore after the reporting period covered within this annual governance statement. However, the Trust has in place staffing systems which assure the board that staffing processes are safe, sustainable and effective. The Trust regularly reviews its acuity levels to ensure services are delivered safely with the right number of staff to deliver the service. This is completed in conjunction with the clinical teams and where available utilises evidence based tools and reflects new legislation / guidance; for example SNCT for adult inpatient wards and Birth Rate Plus for maternity services.

Operational teams undertake daily staffing reviews (risk assessments) are undertaken in line with standard operating procedure which takes into account staff numbers, skill mix and competencies, patient acuity and dependency and activity. Where indicated staff are used flexibly to provide

cover and any risks are formally escalated for action to the staffing co-ordinator and the senior manager on call informed. Where such mitigations are insufficient to address the gap business continuity plans are enacted with escalation to the director on call.

The Trust as an agreed set of workforce performance metrics which are RAG rated against expected performance. These are reported to the board of directors within the monthly integrated performance report. Where metrics is below target remedial actions are included in the report and, where necessary, overseen by a board assurance committee.

The trust has an annual workforce plan which in line with guidance is submitted to the trust board and NHSI on an annual basis. The Trust is currently developing it medium and long term workforce strategy as it prepares to transfer.

All changes to skill mix and introduction of new roles undergo a quality impact assessment which is signed off by the Chief Nurse and Chief Medical Officer.

Care Quality Commission (CQC) registration

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

The 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 inspection report was reported to the Trust Board in January 2018 and rated the hospital as ‘good’.

The trust services were not inspected by the CQC in Q1 of 2018/19. The CQC continued to monitor progress against the CQC action plan arising from the inspection.

Following the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust we submitted a statutory notification to de-register the trust as a provider of healthcare services.

Register of Interests

The trust has published an up-to date register of interests for decision-making staff within the past twelve months, as required the ‘Managing Conflicts of Interest in the NHS’ guidance. The trust continues to embed the process within the organisation.

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.

The trust had not taken into account UK Climate Projections 2018 (UKCP18) as these were published in November 2018. The trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements. The trust ensures that its 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, which remained in force until the merger.

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, financial 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 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 and remained in force up to the date of the merger.

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 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.

The BAF developed in 2017/18 remained in force during Q1 2018/19 and was reported to the Board during this period. Risks scoring 15 and above migrate to the BAF. Six risks were identified with a net severity of 15 +. For each of these, the BAF described the processes and controls in place to manage the risk and what further action is necessary to control the risk.

- 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 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 on 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.

Up to the date of the merger, 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 were 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 four in May 2018 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 2018 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 merger with Colchester Hospital University NHS Foundation Trust to create East Suffolk and North Essex 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 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 Q1 2018/19, the Trust has demonstrated satisfactory performance against some of the key performance indicators. Highlights for the quarter included:

- achievement of the Trust MRSA trajectory, reporting zero cases for the quarter; and
- compliance with the 18-week incomplete pathway threshold of 92% during the quarter.

Exception to good performance during the quarter included the following:

- failure to meet the cancer 62 day target of 85%
- failure to achieve compliance with the 95% threshold for A&E four hour waits across type one and type three new attendances.
- failure to achieve the 99% compliance required on diagnostic tests undertaken within six weeks, achieving 98.31% in June 2018
- the C.difficile figures increased during Q1, breaching the ceiling for the period at eight cases against a ceiling of five.

Performance against the key performance indicators are 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. During Q1, the Trust reported 12 level one incidents and 0 level two incidents relating to breaches of patient confidentiality. Information governance training and awareness have increased to prevent level two incidents which are reportable to the Information Commissioner's Office (ICO).

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). There was no further review during Q1 2018/19.

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 and 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 £6.3m for Q1 2018/19. The Trust exceeded this plan and posted a final deficit of £6.8m during the quarter, including receipt of £0.8m Provider Sustainability Funding (PSF). The Trust delivered its cost improvement programme for the year at a value of £3.6m.

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 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 Q1, the Trust has continued to work 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, including 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), adopted 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 were built into the Trust's annual counter fraud work plan, which was overseen by the Audit Committee. The Audit Committee received assurance on fraud deterrent from regular reports from the Trust's LCFG and LCFS.

The LCFS helped to foster an anti-fraud culture within the Trust by training all staff at induction. This featured 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 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'.

Internal audit

The Q1 audit plan was undertaken by Internal Audit and monitored by the Audit Committee. The table below describes the internal audit reviews undertaken in Q1 and the level of assurance provided.

Audit	**Assurance level provided**
BAF and risk management	Substantial
Estates management – premises assurance model	Substantial
Cancer waits	Limited
Theatre utilisation – data quality	Limited
Outpatients cancellations	Limited

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

- **Cancer waits – 62 day and two week wait** – noting that the Trust had not met the aggregate 62 days national performance target of 85% in 2018 other than in April, the review highlighted a need to update and improve the cancer action plan, review the Patient Access Policy and identified incidences of incorrect recording of dates of first definitive treatment and a referral date on the patient tracking list.

- **Theatre utilisation policy** – this review highlighted the need to update the policy on utilisation of theatres to reflect proposed changes in performance monitoring and to be clearer on the accountability arrangements. Other weaknesses identified included incomplete utilisation figures reported to the Board due to just one of the two theatre IT systems being used to provide information in the Integrated Performance Report and a gap in the formal monitoring and governance with regards to theatre utilisation.

- **Outpatients cancellations** – this review highlighted a lack of adherence to the authorisation process for the cancellation of appointments and clinics, inconsistency in the disaggregation of the Trust's target for outpatient appointments cancelled per month to divisional/specialty level, a need to review and update the Patient Access Policy and to strengthen internal reporting and performance monitoring against the Accountability Framework.

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. This review 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 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 a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk. Recommendations from audit are followed up by the Audit Committee throughout the year and will be handed over to the new organisation as at the 01 July 2018.

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 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, 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 action 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. I have considered the factors described in the NHS Improvement guidance on the annual governance statement in respect of significant issues.

Of the matters identified in this statement, none were considered to be significant control issues by the executive team or assurance committees.

My review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives. 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.

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:

Remuneration and Staff Report (unaudited)

Remuneration policy (not subject to audit)

The Nomination and Remuneration Committee acts with the delegated authority from the Trust Board. Its purpose 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 Trusts' 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.

The notice periods on resignation are as follows:

- Chief Executive – six months
- Executive Directors – three months

The Trust did not have a bonus scheme in operation during the first quarter of 2018/19.

Pension contributions

The Trust made contributions totalling £4.5million 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 benefits in kind)

The Trust has made expense payments to 10 Directors totalling £3,153 during 2018/19 (for three months). In 2017/18, there were payments made to 13 Directors totalling £16,600.

External auditor's remuneration

BDO, the Trust's external auditors, have not undertaken any non-audit work during the quarter. Details of the Trust's performance against the better payments practice code are disclosed in note eight to the accounts.

Salary and pension entitlements of Board members (subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100) £00	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Nick Hulme	Chief Executive	20-25	0	0	0	0-2.5	20-25
Crawford Jamieson	Medical Director	35-40	1	0	10-15	0	50-55
Neill Moloney	Chief Operating Officer/Managing Director	20-25	0	0	0	42.5-45	65-70
Simon Rudkins	Acting Director of Finance	25-30	0	0	0	0	25-30
David White	Chairman	5-10	0	0	0	0	5-10
Tony Thompson	Non-Executive Director	0-5	3	0	0	0	0-5
Andrew George	Non-Executive Director	0-5	0	0	0	0	0-5
Laurence Collins	Non-Executive Director	0-5	0	0	0	0	0-5
Elaine Noske	Non-Executive Director	0-5	0	0	0	0	0-5
Helen Taylor	Non-Executive Director	0-5	0	0	0	0	0-5
Richard Kearton	Non-Executive Director	0-5	0	0	0	0	0-5

Comparative table showing salary and pension entitlements of Board members 2017/18

Name	Title	Salary (bands of £5,000) £000	Long-term performance 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
Nick Hulme	Chief Executive	80 – 85	0	4	52.5 – 55	135 – 140
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 (from 30/09/17)	50 – 55	0	0	212.5 – 215	265 – 270
Dr Crawford Jamieson	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	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 was £212,000 for Nick Hulme and £60,000 for David White.

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 as a clinician. His remuneration for his role as a clinician during this period was £25,000.

Pension benefits for quarter one – Board members (subject to audit)

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2019 £000	Cash equivalent transfer value at 31 March 2018 £000	Real increase in cash equivalent transfer value £000	Employers contributions to stakeholder pension £000
Nick Hulme	0 – 2.5	0 – 2.5	55 – 60	165 – 170	1296	1143	23	0
Neill Moloney	0 – 2.5	2.5 – 5	55 – 60	135 – 140	1012	752	52	0
Crawford Jamieson	0 – 2.5	0 – 2.5	55 – 60	140 – 145	1096	1110	0	0
Simon Rudkins	0 – 2.5	0 – 2.5	20 – 25	45 – 50	351	385	0	0

The financial information in the table above is derived from information provided to the Trust from the NHS Pensions Agency. Whilst the Trust accepts responsibility for the disclosed values, the Trust is reliant upon NHS Pensions Agency for the accuracy of the information provided to it and has no way of auditing these figures. The figures are therefore shown in good faith as an accurate reflection of the senior managers' pensions information.

There will be no entries in respect of pensions for Non-Executive Directors, as they do not receive pensionable remuneration.

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 valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual had transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Median staff pay disclosure (subject to audit)

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 2018/19 was £203,145 (annualised) (2017/18: £125,051). This was 7.2 times (2017/18: 4.4) the median remuneration of the workforce, which was £28,050

(2017/18: £28,519). Changes in the ration relate to a pay review for Executive Directors and was in recognition of taking on additional roles and responsibilities and to recognise cost of living increases.

In 2018/19, five (2017/18: 85) employees received remuneration in excess of the highest paid Director. Remuneration ranged from £7,235 to £314,414 (2017/18: £6,843 – £299,912). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions

Staff report

We continue 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 the trust as a place to work, receive treatment and be trained.

Staff costs 2018/19 quarter one (subject to audit)

	2018/19			
	£000s	£000s	£000s	£000s
	Total	Permanently employed	Agency/Contract	Other
Salaries and wages	41,675	37,124	2,587	1,964
Social security costs	3,276	2,980		296
Apprenticeship levy	192	192		
NHS Pension Scheme	4,472	4,312		160
Other pension costs				
	49,615	**44,608**	**2,587**	**2,420**
Costs capitalised as part of assets	18	15		3
Total employee benefits (excluding capitalised costs)	**49,633**	**44,623**	**2,587**	**2,423**

Staff numbers by WTE for quarter one (subject to audit)

Average staff numbers	2018/19			2017/18
	Total number	Permanently employed number	Other	Total number
Ambulance staff	0	0		0
Administration and estates staff	892	850	42	892
Healthcare assistants and other support staff	175		175	904
Medical and dental staff	868	860	8	493
Nursing, midwifery and health visiting staff	1,472	1,326	146	1,367
Scientific, therapeutic and technical staff	477	465	12	471
Healthcare scientists	58	58	1	53
Total	3,942	3,559	384	4,180

Staff gender breakdown for quarter one

	2018/19 (Q1) Number		2017/18 Number	
	Female	Male	Female	Male
Contracted staff	3,861	945	3,833	943
The Trust maintains a bank of staff who can be called on as required	2,425	418	2,905	571
Total	6,286	1,363	6,738	1,514

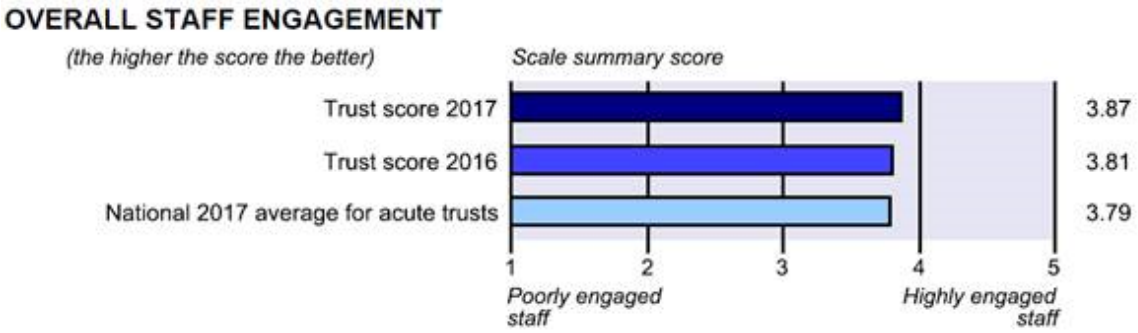
Board gender and pay scale breakdown for quarter one

	2018/19 (Q1) Number		2017/18 Number	
	Female	Male	Female	Male
Non-Executive Director	2	5	2	5
Very senior manager	4	7	5	9
Total	6	12	7	14

NHS Staff Survey

The national NHS staff survey was sent to all staff. 1930 staff responded, a 46% response rate, which was the same as 2016 but above average for acute trusts (44%).

The results highlighted a high level of staff engagement at the Trust as this diagram shows:



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.

Recruitment of staff

Initiatives to recruit to difficult to fill posts and to reduce the number of times that staff are required to work extra hours are ongoing. As part of the workforce strategy review and non-

mandatory training provisions, we will also be looking at training, information, and communication needs and other ways of addressing this.

Our 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.

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.

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, 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)

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.

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.

Care Quality Commission / equality diversity and human rights agenda

Equality and diversity are 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 4.06% (12 months to 30 June 2018). This compares to 4.03% in March 2018.

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 trust's 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.

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.

Off-payroll engagements for quarter one

Off-payroll engagements lasting longer than six months:

	Number
Number of existing engagements as of 30 June 2018	2
Of which, the number that have existed:	
for less than one year at the time of reporting	
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	1
for between three and four years at the time of reporting	
for four or more years at the time of reporting	

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.

New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 30 June 2018	0

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

	2017/18	2018/19
	Year	Quarter
Total hours lost	305,942	72,555
Total staff years	3,860	4,019
Average working hours lost	79.26	18,05
Persons retired on health grounds	2	3

Exit packages and severance payments for quarter one (subject to audit)

There were four exit packages agreed in the quarter

	2018/19 (Q1)			
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	0	0	4	5,556
£25,001 - £50,000	0	0	0	0
Total	**0**	**0**	**4**	**5,556**

Redundancy and other departure costs have been paid in accordance with the provision 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 Pension Scheme. Ill health retirement costs are met by the NHS Pension Scheme and are not included in the table.

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

Exit packages – other departures analysis for quarter one (subject to audit)

There were no exit packages for other departures in quarter one of 2018/19 (2017/18 none).

There were no non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary (2017/18 none).

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

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

Appendix: Accounts for quarter one

The Ipswich Hospital NHS Trust

Accounts for the period

1 April 2018 to 30 June 2018

FOREWORD TO THE ACCOUNTS
THE IPSWICH HOSPITAL NHS TRUST

These accounts for the period ended 30 June 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 period ended 30 June 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 and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2018-19 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of The Ipswich Hospital NHS Trust as at 30 June 2018 and of its expenditure and income for the period then ended; and
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2018-19; and
- have been prepared in accordance with the Health and Social Care Act 2012.

Basis for opinion on financial statements

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

Emphasis of matter – basis of preparation of financial statements

As explained in Note 1.1 to the financial statements, although the Trust's operations have now been merged with those of Colchester Hospital University NHS Foundation Trust the Trust's financial statements have been prepared on a going concern basis in accordance with the requirements of the Group Accounting Manual 2018-19. 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, being:

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

In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018-19.

Report to the Secretary of State

On 29 May 2018 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust has been unable to achieve a breakeven position since 2003/04.

Other matters

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

- in our opinion the Annual Governance statement does not comply with the guidance issued by NHS Improvement; 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' reponsibilities in respect of the acconts, the 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 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 the Directors either intend to liquidate the Trust or 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 ensuring that value for money is achieved from the resources available to the Trust.

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), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountabilty 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 our 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.

David Eagles
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK

28 May 2019

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

Statement of Comprehensive Income for the period ended 30 June 2018

		30 June 2018	2017/18
	NOTE	**£000**	£000
Gross employee benefits	6.1	(49,615)	(187,520)
Other operating costs	5	(36,665)	(142,271)
Revenue from patient care activities	3	73,835	283,727
Other operating revenue	4.1	6,567	37,902
Operating deficit from continuing operations		**(5,878)**	**(8,162)**
Investment Revenue		13	21
Finance costs		(710)	(2,804)
Deficit for the financial year		(6,575)	(10,945)
Public dividend capital dividends payable		(166)	(1,164)
Retained deficit for the financial year		**(6,741)**	**(12,109)**
Other comprehensive income			
Impairments and reversals taken to the revaluation reserve		(23)	(3,163)
Revaluation of property, plant and equipment		1,346	2,648
Other reserves movements		5	-
Total comprehensive expense for the year		**(5,413)**	**(12,624)**

Financial performance for the period		
Retained deficit for the year	**(6,741)**	(12,109)
IFRIC 12 adjustment (including IFRIC 12 impairments)		(983)
Impairments (excluding IFRIC 12 impairments)	**147**	106
Adjustments in respect of donated/gov't grant asset reserve elimination	**32**	(446)
Adjusted retained deficit	**(6,562)**	**(13,432)**

NHS Trusts have a statutory requirement to break even year on year. The Department of Health and Social Care 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 11 to 38 form part of this account.

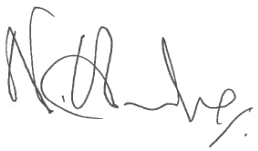
THE IPSWICH HOSPITAL NHS TRUST WAS ACQUIRED BY COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST ON 1 JULY 2018. ALL FIGURES REPORTED IN 2018/19 ARE THEREFORE FOR A PERIOD OF 3 MONTHS ONLY. FIGURES FOR 2017/18 ARE FOR A FULL FINANCIAL YEAR.

Statement of Financial Position as at 30 June 2018

	NOTE	30 June 2018 £000	2017/18 £000
Non-current assets			
Intangible assets	8.1	4,609	4,838
Property, plant and equipment	8.3	136,201	137,275
Trade and other receivables	9.1	3,273	3,179
Total non-current assets		**144,083**	145,292
Current assets			
Inventories		5,350	5,339
Trade and other receivables	9.1	27,165	26,364
Cash and cash equivalents	10	866	1,356
Total current assets		**33,381**	33,059
Total assets		**177,464**	178,351
Current liabilities			
Trade and other payables	11	(33,332)	(33,838)
Borrowings	12	(1,799)	(1,727)
DH Revenue support loan	12	(17,626)	(17,324)
Provisions	15	(370)	(295)
Total current liabilities		**(53,127)**	**(53,184)**
Total assets less current liabilities		**124,337**	125,167
Non-current liabilities			
Provisions	15	(956)	(989)
Borrowings	12	(25,300)	(25,956)
DH Revenue support loan	12	(56,712)	(51,440)
Total non-current liabilities		**(82,968)**	(78,385)
Total assets employed		**41,369**	46,782
Financed by			
Public dividend capital		95,895	95,895
Revaluation reserve		25,575	24,599
Income and expenditure reserve		(80,101)	(73,712)
Total taxpayers' equity		**41,369**	46,782

The notes on pages 11 to 38 form part of these accounts.

The financial statements on pages *7* to 38 were approved by the Board on 28 May 2019 and signed on its behalf by;



Nick Hulme, Chief Executive

Statement of Changes in Equity for the period ended 30 June 2018

	Public dividend capital £000	Revaluation reserve £000	Retained Earnings £000	Total £000
Balance at 1 April 2018	**95,895**	**24,599**	**(73,712)**	**46,782**
Changes in Taxpayers' equity for 2018-19				
Deficit for the year	-	-	(6,741)	**(6,741)**
Other transfers between reserves	-	(347)	347	**-**
Impairments and reversal of impairments	-	(23)	-	**(23)**
Revaluations	-	1,346	-	**1,346**
Other movement on reserves	-	-	5	**5**
Net recognised revenue/(expense) for the year	-	976	(6,389)	(5,413)
Taxpayers' equity at 30 June 2018	**95,895**	**25,575**	**(80,101)**	**41,369**

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 and reversal of 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**

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

Income and expenditure reserve

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

Statement of Cash Flows For the Period Ended 30 June 2018

	NOTE	**30 June 2018 £000**	2017/18 £000
Cash flows From Operating Activities			
Operating deficit		(5,878)	(8,162)
Non-cash income and expense:			
Depreciation and amortisation	8	2,598	9,922
Impairments and reversals		147	(877)
(Increase)/decrease in inventories		(11)	(297)
(Increase)/decrease in Trade and Other Receivables		(713)	1,996
Increase/(decrease) in Trade and Other Payables		51	(6,588)
Increase/(decrease) in non cash provisions		42	(323)
Net Cash Outflow from Operating Activities		**(3,764)**	**(4,329)**
Cash flows from investing activities			
Interest received		13	21
Payments for Property, Plant and Equipment		(720)	(10,341)
Payments for intangible assets		41	(1,080)
Payments for Other Financial Assets		-	-
Proceeds of disposal of assets held for sale (PPE)		-	-
Net Cash Outflow from Investing Activities		**(666)**	**(11,400)**
Net Cash Outflow before Financing		**(4,430)**	**(15,729)**
Cash flows from Financing Activities			
Gross Temporary and Permanent PDC Received		-	2,393
Loans received from DH - New Revenue Support Loans		5,272	19,962
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI		(781)	(1,850)
Interest Paid		(621)	(2,726)
PDC Dividend paid		-	(1,084)
Other financing activities		70	(553)
Net Cash Inflow from Financing Activities		**3,940**	16,142
NET INCREASE IN CASH AND CASH EQUIVALENTS		**(490)**	413
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,356**	943
Cash and Cash Equivalents (and Bank Overdraft) at year end	10	**866**	1,356

NOTES TO THE ACCOUNTS

1 Accounting Policies

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Gam permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. 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.

After taking into account all relevant factors, the Board has determined that the accounts should be prepared on a going concern basis for the period ended 30 June 2018 based on the following factors:

In June 2018, NHS Improvement approved the acquisition of the Trust by Colchester Hospital University NHS Foundation Trust and for the combined organisation to be subsequently known as East Suffolk and North Essex NHS Foundation Trust. Following that decision, the Board had a clear and fixed intention for the acquisition to proceed on 1 July 2018 and that there was no reason to believe that this would not be achieved.

The Trust had submitted a joint financial plan for the remainder of the financial year to the end of March 2019 and main commissioners had supported the acquisition proposal and the continuation of previously agreed contracts, all of which had been signed as at 31 March 2018.

As directed by the GAM 2018/19, 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. In that respect, all of the services provided previously by The Ipswich Hospital NHS Trust have now been taken on and are being provided by East Suffolk and North Essex NHS Foundation Trust, and these services will continue to be delivered using the same assets as acquired from the Trust.

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 provide an indicative desktop revaluation index as a proxy to estimate the valuation movement of the Trust's estate between 1 April 2018 and 30 June 2018.

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 on 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 £136.2m (2017/18, £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 equivalent asset.
Adjustments for obsolescence: Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and 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 from Contracts with Customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

NOTES TO THE ACCOUNTS

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.

The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from Research Contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS Injury Cost Recovery Scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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 such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Pension 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.

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

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

1.6 Other Expenses

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

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 functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, 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 costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Revaluation

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

NOTES TO THE ACCOUNTS

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The contribution is charged to expenditure. The total value of clinical negligence provisions carried by NHS Resolution is not recognised in the Trust's accounts.

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. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS. 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 list of recently issued International Financial Reporting Standards and amendments have not yet been adopted within the FReM, and are therefore not applicable to Department of Health and Social Care group accounts in 2018/19. Other than IFRS16 (see below), none of these are expected to impact upon the Trust financial statements.

IFRS 14 Regulatory Deferral Accounts: Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applcable to DHSC group bodies.

IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is 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 23 Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1 January 2019.

1.19 Early Adoption of Standards, Amendment and Interpretations

No new accounting standards or revisions to existing standards have been adopted in the accounting period to 30 June 2018.

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)

	30 June 2018 £000	2017/18 £000
Acute services		
Elective income	13,449	53,359
Non elective income	17,443	71,503
First outpatient income	5,034	20,990
Follow up outpatient income	5,808	22,120
A & E income	2,997	11,604
High cost drugs income from commissioners (excluding pass-through costs)	7,677	25,601
Other NHS clinical income	10,864	49,590
Community services income from CCGs and NHS England*	9,700	18,175
Income from other sources (e.g. local authorities)	141	5,067
Private patient income	209	843
Other clinical income	513	4,875
Total income from activities	**73,835**	**283,727**

3.1 Income from patient care activities (by source)

	30 June 2018 £000	2017/18 £000
NHS England	12,109	47,725
Clinical commissioning groups*	61,712	224,459
Other NHS providers	1,025	8,045
NHS other	34	6
Department of Health and Social Care	7	-
Non-NHS:		
Local Authorities	(1,608)	892
Private patients	209	843
Overseas patients (non-reciprocal)	62	199
Injury costs recovery	235	758
Other Non-NHS patient care income	50	800
Total income from activities	**73,835**	283,727

***** 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

	30 June 2018 £000	2017/18 £000
Recoveries in respect of employee benefits	749	2,803
Education, training and research	2,577	10,677
Charitable and other contributions to expenditure	1	19
Receipt of charitable donations for capital acquisitions	76	875
Non-patient care services to other bodies	204	835
Income generation (other fees and charges)	1,341	3,747
Provider Sustainability Funding	787	11,049
Rental revenue from operating leases	53	226
Other income	779	7,671
Total other operating income	**6,567**	37,902
Total Operating Revenue	**80,402**	321,629

Included in other income in 2017/18 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

	30 June 2018 £000	2017/18 £000
Income recognised this year	62	199
Cash payments received in-year	5	59
Amounts added to provision for impairment of receivables	19	82
Amounts written off in-year	-	26

5. Operating expenses

	30 June 2018 £000	2017/18 £000
Total Services from NHS Bodies*	2,406	12,630
Purchase of healthcare from non-NHS and non-DHSC bodies	120	12,043
Remuneration of non-executive directors	16	65
Supplies and services - clinical (excluding drugs costs)	11,016	25,186
Supplies and services - general	3,394	14,654
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	9,109	36,390
Consultancy costs	12	423
Establishment	885	7,690
Premises	2,508	7,035
Transport (including patient travel)	27	313
Depreciation on property, plant and equipment	2,239	8,586
Amortisation on intangible assets	359	1,336
Net impairments	147	(877)
Movement in credit loss allowance: contract receivables/assets	142	215
Increase in other provisions	44	46
Change in provisions discount rate(s)	-	9
Audit fees payable to the external auditor**		
audit services- statutory audit	38	51
other auditor remuneration (external auditor only)	-	34
Internal audit costs	33	130
Clinical negligence	2,828	13,185
Legal fees	-	211
Insurance	-	49
Education and training	123	628
Rentals under operating leases	595	353
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	230	815
Hospitality	-	92
Losses, ex gratia & special payments	-	331
Other	394	648
Total Operating Expenses (excluding employee benefits)	**36,665**	142,271
Employee Benefits		
Employee benefits excluding Board members	49,269	186,221
Board members	346	1,299
Total Employee Benefits	49,615	187,520
Total Operating Expenses	**86,280**	329,791

*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 (2017/18: £1m)

NOTES TO THE ACCOUNTS

6 Employee Benefits

6.1 Employee Benefits

	30 June 2018 Total £000	2017/18 Total £000
Employee Benefits - Gross Expenditure		
Salaries and wages	41,693	157,403
Social security costs	3,276	13,376
Apprenticeship levy	192	729
Employer's contributions to NHS pensions	4,472	17,247
Total Employee Benefits	**49,633**	188,755
Less: Recoveries in respect of seconded staff	**-**	782
	49,633	187,973
Employee costs capitalised	**18**	453
Employee Benefits excluding capitalised costs	**49,615**	187,520

6.2 Retirements due to ill-health

For the period to 30 June 2018 there was 1 early retirement from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £16k (£101k in 2017/18).

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 the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

NOTES TO THE ACCOUNTS

7. Better Payment Practice Code

7.1 Measure of compliance

	30 June 2018 Number	**30 June 2018 £000**	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	22,092	46,851	78,433	190,957
Total non-NHS trade invoices paid within target	19,187	40,065	34,230	84,274
Percentage of non-NHS trade invoices paid within target	**86.85%**	**85.52%**	43.64%	44.13%
NHS Payables				
Total NHS trade invoices paid in the year	643	12,236	1,977	25,519
Total NHS trade invoices paid within target	457	7,181	725	9,119
Percentage of NHS trade invoices paid within target	**71.07%**	**58.69%**	36.67%	35.73%

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.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

	30 June 2018 £000	2017/18 £000
Amounts included within interest payable arising from claims made under this legislation	-	25
Total	-	25

NOTES TO THE ACCOUNTS

8.1 Intangible Assets

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost or valuation:			
At 1 April 2018	**13,547**	**-**	**13,547**
Additions Purchased	(41)	-	**(41)**
Reclassifications	171	-	**171**
Disposals other than for sale	(3,674)	-	**(3,674)**
Valuation/gross cost at 30 June 2018	**10,003**	**-**	**10,003**
Amortisation			
At 1 April 2018	**8,709**	**-**	**8,709**
Disposals other than for sale	(3,674)	-	**(3,674)**
Charged during the year	**359**	**-**	**359**
At 30 June 2018	**5,394**	**-**	**5,394**
Net book value at 30 June 2018	**4,609**	**-**	**4,609**

8.2 Intangible Assets prior-year

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost or valuation:			
At 1 April 2017	**12,413**	**54**	**12,467**
Additions of Assets Under Construction			**-**
Additions Purchased	608	51	**659**
Additions - Purchases from Cash Donations & Government Grants	-		**-**
Additions Leased (including PFI/LIFT)			**-**
Reclassifications	526	(105)	**421**
Valuation/gross cost at 31 March 2018	**13,547**	**-**	**13,547**
Amortisation			
At 1 April 2017	**7,373**	**-**	**7,373**
Charged during the year	**1,336**	**-**	**1,336**
At 31 March 2018	**8,709**	**-**	**8,709**
Net book value at 31 March 2018	**4,838**	**-**	**4,838**

NOTES TO THE ACCOUNTS

8.3 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 2018	**6,380**	**109,520**	**2,743**	**42,836**	**9,503**	**3,402**	**174,384**
Additions of Assets Under Construction	-	-	7	-	-	-	**7**
Additions Purchased	-	22	-	52	2	1	**77**
Additions - Purchases from Cash Donations & Government Grants	-	25	-	51	-	-	**76**
Reclassifications	-	250	(807)	-	381	5	**(171)**
Disposals other than for sale	-	(3,599)	(717)	(1,080)	(4,900)	(928)	**(11,224)**
Impairments/reversals charged to operating expenses	-	751	-	-	-	-	**751**
Impairments/reversals charged to reserves	-	(23)	-	-	-	-	**(23)**
Revaluations	-	1,346	-	-	-	-	**1,346**
Valuation/gross cost at 30 June 2018	**6,380**	**108,292**	**1,226**	**41,859**	**4,986**	**2,480**	**165,223**
Depreciation							
At 1 April 2018	**-**	**3,618**	**-**	**23,637**	**7,180**	**2,674**	**37,109**
Disposals other than for sale	-	(3,599)	(717)	(1,080)	(4,900)	(928)	**(11,224)**
Impairments/reversals charged to operating expenses		-	717	178	1	2	**898**
Charged during the year	**-**	**1,062**	**-**	**867**	**244**	**67**	**2,240**
At 30 June 2018	**-**	**1,081**	**-**	**23,602**	**2,525**	**1,815**	**29,023**
Net book value at 30 June 2018	**6,380**	**107,211**	**1,226**	**18,257**	**2,461**	**665**	**136,200**
Asset financing:							
Owned - purchased	6,380	77,072	1,226	11,881	2,414	605	**99,578**
Finance leased	-	2,044	-	5,264	-	-	**7,308**
On-SoFP PFI contracts and other service concession arrangements	-	22,319	-	-	-	-	**22,319**
Owned - government granted	-	395	-	136	-	1	**532**
Owned - donated	-	5,381	-	976	47	59	**6,463**
Total at 31 March 2018	**6,380**	**107,211**	**1,226**	**18,257**	**2,461**	**665**	**136,200**

8.4 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 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	-	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**

NOTES TO THE ACCOUNTS

8.5 Property, Plant and Equipment (Continued)

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 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	
	30 June 2018	31 March 2018	**30 June 2018**	31 March 2018
	£000	£000	**£000**	£000
Contract receivables	8,793	8,976	-	-
Contract assets	13,629	13,987	-	-
Allowance for impaired contract receivables/assets	(1,541)	(1,356)	(262)	(256)
Prepayments (non-PFI)	4,294	3,211	-	-
PFI lifecycle prepayments	2,061	-	-	1,864
PDC dividend receivable	-	15	-	-
VAT receivable	104	183	-	-
Other receivables	1,886	1,348	1,474	1,571
Total	**29,226**	26,364	**1,212**	3,179
Of which receivable from NHS and DHSC group bodies:	**20,230**	19,854	**-**	-

	30 June 2018	31 March 2018
Total current and non-current receivables	**30,438**	29,543

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

	30 June 2018	31 March 2018
	£000s	£000s
By up to three months	3,270	5,550
By three to six months	2,339	1,404
By more than six months	1,613	831
Total	**7,222**	7,785

Of the unimpaired receivables, £1,413k are non-NHS, of which £402k are more than 3 months past their due date.

NOTES TO THE ACCOUNTS

10 Cash and Cash Equivalents

	30 June 2018 £000	31 March 2018 £000
Opening Balance	**1,356**	943
Net change in year	(490)	413
Closing Balance	**866**	1,356
Made up of		
Cash with the Government Banking Service	862	1,352
Cash in hand	4	4
Cash and Cash Equivalents as in Statement of Financial Position	**866**	1,356
Cash and Cash Equivalents as in Statement of Cash Flows	**866**	1,356

11 Trade and Other Payables

	30 June 2018 £000	31 March 2018 £000
Trade payables	10,819	9,504
Accruals *	15,697	16,840
Capital payables	44	407
Deferred Income	2,457	2,589
Social security costs	2,146	2,207
Tax	1,859	1,880
Accrued interest on DHSC loans	-	213
Payments received on account	7	46
Other	303	152
Total payables	**33,332**	33,838
Of which payable to NHS and DHSC group bodies:	**5,511**	5,790
Included above:		
Outstanding Pension Contributions at the period end	2,471	2,423

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 12. IFRS 9 is applied without restatement therefore comparatives have not been restated.

NOTES TO THE ACCOUNTS

12 Borrowings

	30 June 2018 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	17,626	17,324
Obligations under finance leases	906	898
Obligations under PFI, or other service concession contracts (excl. lifecycle)	893	829
Total current borrowings	**19,425**	19,051
Non-current		
Loans from the Department of Health and Social Care	56,712	51,440
Obligations under finance leases	4,963	5,347
Obligations under PFI, or other service concession contracts	20,337	20,609
Total non-current borrowings	**82,012**	77,396

12.1 Reconciliation of liabilities arising from financing activities

	DHSC loans	Finance leases - with a non-DHSC group counterparty	PFI and other service concession obligations	Total liabilities from financing activities
Carrying value at 1 April 2018 - brought forward	**68,764**	**6,245**	**21,438**	**96,447**
Impact of applying IFRS 9 as at 1 April 2018	213	-	-	**213**
Cash movements:				
Financing cash flows - principal	5,272	(376)	(405)	**4,491**
Financing cash flows - interest (for liabilities measured at amortised cost)	(143)	(79)	(192)	**(414)**
Non-cash movements:				
Additions	-	-	197	**197**
Interest charge arising in year (application of effective interest rate)	232	79	192	**503**
Carrying value at 31 March 2019	**74,338**	**5,869**	**21,230**	**101,437**

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.

	30 June 2018 Buildings £000	30 June 2018 Other £000	30 June 2018 Total £000	31 March 2017 Total £000
Gross lease liabilities	**1,133**	**6,146**	**7,279**	7,716
of which liabilities are due:				
Not later than one year;	146	1,099	1,245	1,255
Later than one year and not later than five years;	585	3,602	4,187	4,177
Later than five years.	402	1,445	1,847	2,284
Finance charges allocated to future periods	(237)	(1,173)	(1,410)	(1,471)
Net lease liabilities	**896**	**4,973**	**5,869**	6,245
of which payable:				
Not later than one year;	94	812	906	898
Later than one year and not later than five years;	432	2,837	3,269	3,269
Later than five years.	369	1,325	1,694	2,078

NOTES TO THE ACCOUNTS

14 Operating Leases

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

	30 June 2018 £000	31 March 2018 £000
Operating lease revenue		
Contingent rent	53	226
Total	**53**	226

	30 June 2018 £000	31 March 2018 £000
Future minimum lease receipts due:		
Not later than one year;	137	144
Later than one year and not later than five years;	385	392
Later than five years.	1,905	1,927
Total	**2,427**	2,463

14.2 Operating Lease Payments and Commitments (Trust as Lessee)

	30 June 2018 £000	31 March 2018 £000
Operating lease expense		
Minimum lease payments	595	353
Total	**595**	353

	30 June 2018 £000	31 March 2018 £000
Future minimum lease payments due:		
Not later than one year;	1,868	2,008
Later than one year and not later than five years;	6,233	5,394
Later than five years.	400	1,601
Total	**8,501**	9,003

NOTES TO THE ACCOUNTS

15.1 Finance Income

	30 June 2018 £000	2017/18 £000
Interest income of short-term bank deposits	**13**	21
	13	21

15.2 Finance Costs

	30 June 2018 £000	2017/18 £000
Finance Leases	**79**	947
Loans from the Department of Health and Social Care	**232**	278
Other interest payable	**-**	25
PFI main finance cost	**192**	797
PFI contingent finance cost	**207**	755
	710	2,802

NOTES TO THE ACCOUNTS

16 Provisions

	Pensions - early departure costs £000	Pensions - injury benefits £000	Legal claims £000	Other £000	Total £000
Balance a 1 April 2018	**185**	**871**	**46**	**182**	**1,284**
Change in the discount rate	-	-	-	-	**-**
Arising during the year	-	-	-	44	**44**
Utilised during the year	-	-	(2)	-	**(2)**
Unwinding of discount	-	-	-	-	**-**
Balance at 30 June 2018	**185**	**871**	**44**	**226**	**1,326**
Expected timing of cash flows:					
Not later than one year;	39	61	44	226	**370**
Later than one year and not later than five years;	109	241	-	-	**350**
Later than five years.	37	569	-	-	**606**
Total	**185**	**871**	**44**	**226**	**1,326**

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

	£000
As at 30 June 2018 *	**-**
As at 31 March 2018	221,142

* The figure as at 30 June 2018 is not available as it has not been estimated by NHS Resolution as at that date. The estimate for clinical negligence liabilities has subsequently been incorporated into the figure provided to East Suffolk and North Essex NHS Foundation Trust and has been reported as at 31 March 2019 in the accounts of that organisation.

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

17 PFI - additional information

The Trust has no off SOFP PFI contracts

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

	2018/19	2017/18
	£000	£000
Service element of on SOFP PFI charged to operating expenses in year	230	815
Total	**230**	815

Payments committed to in respect of the service element of on SOFP PFI		
No Later than One Year	893	823
Later than One Year, No Later than Five Years	3,572	3,292
Later than Five Years	10,700	10,700
Total	**15,165**	14,815

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

	2018/19	2017/18
	£000	£000
Not later than one year;	1,656	1,597
Later than one year and not later than five years;	7,293	7,293
Later than five years.	20,092	20,549
Subtotal	**29,041**	29,439
Less: Interest Element	(7,810)	(8,001)
Total	**21,231**	21,438

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2018/19**	2017/18
Analysed by when PFI payments are due	**£000**	£000
Not later than one year;	893	829
Later than one year and not later than five years;	4,618	4,576
Later than five years.	15,720	16,033
	21,231	21,438

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

18 Financial Instruments

18.1 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 30 June 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 Resource Limit. The Trust is not, therefore, exposed to significant liquidity risks.

18.2 Financial Assets

	Loans and receivables £000	Total £000
Contract receivables and assets excluding non financial assets	23,979	**23,979**
Cash and cash equivalents at bank and in hand	866	**866**
Total at 30 June 2018	**24,845**	**24,845**

	Loans and receivables £000	Total £000
Contract receivables and assets 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**

NOTES TO THE ACCOUNTS

18 Financial Instruments (continued)

18.3 Financial Liabilities

	Other financial liabilities £000	Total £000
Borrowings excluding finance lease and PFI liabilities	74,338	**74,338**
Obligations under finance leases	5,869	**5,869**
Obligations under PFI and other service concession contracts	21,230	**21,230**
Trade and other payables excluding non financial liabilities	26,863	**26,863**
Total at 30 June 2018	**128,300**	**128,300**

	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 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**

	30 June 2018 £000	31 March 2018 £000
In one year or less	46,288	48,032
In more than one year but not more than two years	51,440	33,514
In more than two years but not more than five years	13,158	25,771
In more than five years	17,414	16,247
Total	**128,300**	123,564

NOTES TO THE ACCOUNTS

19 Events after the end of the reporting period

On 30 June 2018, The Ipswich Hospital NHS Trust ceased to exist due to a formal acquisition by Colchester Hospital University NHS Foundation Trust, as approved by NHS Improvement in June 2018.

The net relevant assets of the Trust were transferred to East Suffolk and North Essex NHS Foundation Trust on 1 July 2018 by means of a Deed of Transfer, as approved by the Secretary of State for Health.

All of the services that were previously provided by the Trust were taken over and continue to be provided as part of the acquisition.

The accounts for The Ipswich Hospital NHS Trust have been prepared on a going concern basis as the services previously provided by the Trust have been retained and continued by the acquiring trust which is in accordance with guidance by HM Treasury on mechanics of Government changes to NHS organisations.

20 Related Party Transactions

During the year none of the Department of Health and Social Care 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 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
West Suffolk NHS Foundation Trust

NHS Trusts
St Helens and Knowsley Hospital Services NHS Trust

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

Other Bodies
Health Education England
NHS Resolution (formerly NHS Litigation Authority)
NHS Property Services
Department of Health and Social Care
HM Revenue & Customs
NHS Pension Scheme
NHS Blood and Transplant

NOTES TO THE ACCOUNTS

21 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.

21.1 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	2018/19 £000
Breakeven duty in-year financial performance	3,351	1,260	137	205	50	(11,893)	(22,098)	(17,578)	(13,432)	(6,560)
Breakeven duty cumulative position	(5,005)	(3,745)	(3,608)	(3,403)	(3,353)	(15,246)	(37,344)	(54,922)	(68,354)	(74,914)
Operating income	225,962	235,136	238,150	236,732	249,439	250,597	266,310	296,451	321,629	80,402
Cumulative breakeven position as a percentage of operating income	(2.2%)	(1.6%)	(1.5%)	(1.4%)	(1.3%)	(6.1%)	(14.0%)	(18.5%)	(21.3%)	(93.2%)

NOTES TO THE ACCOUNTS

21.2 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%.

21.3 External Financing

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

	2018/19	2017/18
	£000	£000
External financing limit (EFL)	4,981	21,921
Cash flow financing	4,981	19,515
Finance leases taken out in year	-	1,687
External financing requirement	**4,981**	21,202
Under spend against EFL	**-**	719

21.4 Capital Resource Limit

	2018/19	2017/18
	£000	£000
Gross capital expenditure	119	12,683
Less: Disposals	-	-
Less: Donated and granted capital additions	(76)	(875)
Charge against Capital Resource Limit	**43**	11,808
Capital Resource Limit	**43**	11,903
Under spend against CRL	**-**	95

22 Transfer by Absorption

The Trust was acquired by Colchester Hospital University NHS Foundation Trust (subsequently renamed East Suffolk and North Essex NHS Foundation Trust) on 1 July 2018. A loss of £41,369k is to be recognised in the SOCI from this transfer by absorption. This represents the value at the date of transfer of the net assets and liabilities transferred.

The value of assets and liabilities transferred is below.

	£000
Assets	
Property, plant and equipment	(136,201)
Intangible assets	(4,609)
Contract receivables and other assets	(30,438)
Inventories	(5,350)
Cash	(866)
Total assets transferred	(177,464)
Liabilities	
Current trade and other payables	33,332
Borrowings	101,437
Provisions	1,326
Total liabilities transferred	136,095
Total net assets transferred	**(41,369)**

NOTES TO THE ACCOUNTS

23 Losses and Special Payments

	30 June 2018 Total Number of Cases £000	30 June 2018 Total Value of Cases £000	2017/18 Total Number of Cases	2017/18 Total Value of Cases
Losses:				
Bad debts and claims abandoned in relation to:				
a. private patients	-	-	5	1
b. overseas visitors	-	-	5	26
c. other	-	-	30	17
Damage to buildings, property etc. (including stores losses) due to:				
a. other	-	-	1	275
Total losses	**-**	**-**	**41**	**319**
Special payments:				
Ex gratia payments in respect of:				
a. loss of personal effects	13	4	37	11
b. other	3	-	4	1
Total special payments	**16**	**4**	**41**	**12**
Total losses and special payments	**16**	**4**	**82**	**331**