NHS
West Suffolk
NHS Foundation Trust

Annual report and accounts

2019/20

Putting you first

West Suffolk NHS Foundation Trust

Annual Report and Accounts 2019/20

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

Contents

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

1. Performance report

1.1 Overview

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

1.1.1 A message from the chair and chief executive

This report is published during a year in which the National Health Service is being called upon to meet the greatest challenge in the 72 years of its existence due to the coronavirus pandemic. Our colleagues across the WSFT are daily proving their resilience and their commitment to providing excellent and compassionate care for the people of Suffolk.

In our acute and community services, frontline staff are showing their courage, skill and professionalism in safely treating every patient according to their individual need. Supporting them are cleaners and catering teams, technicians and IT colleagues, administrators and educators. Now more than ever, we know that our greatest asset is our workforce.

Responding to the pandemic has shown the value of all the work we have done to take an alliance approach with our partners across all public services throughout Suffolk and north Essex. The close ties we have forged have enabled us to join up care where it is needed, closer to home, making the best use of all our resources and improving patient experience. More and more people are able to be cared for where they live, achieving greater independence and better quality of life for as long as possible.

Even before the coronavirus crisis, the Trust had experienced a turbulent year which caused us to examine the culture of our organisation while at the same time celebrating the commitment of our staff. A full inspection by the Care Quality Commission (CQC) resulted in our being given a rating of “requires improvement”. As we had previously been rated “outstanding” this was a great disappointment and as leaders we have offered our sincere apologies.

The CQC sought action on things the Trust must do and where improvement is needed. These included some areas not fully managing infection risks, medicines management or record keeping, and staff not always feeling able to raise concerns. It is important to note that the CQC rated many of our services as good or outstanding and found that across the board patients were treated with compassion and respect.

All our employees were invited to respond to this year’s NHS staff survey, which brought encouraging findings, as did the staff friends and family test, with positive comparisons regionally and nationally. At the same time it is clear we need to listen more to our colleagues, be informed by their views, offer specific support to teams and have a greater focus on leadership and continuous learning.

We are reviewing our culture and openness to make sure everyone – including our patients, our staff and our commissioners – can contribute to our improvement. We are supporting staff conversations, reviewing our HR policies and pursuing the Better Working Lives initiative. We have developed a robust improvement plan, and progress on this will be monitored by our Board and reported to the CQC. We welcome and will fully co-operate with the independent review commissioned by the Department of Health into whistleblowing concerns.

Across the year we have seen an average increase of ten per cent in attendance at the hospital, and a consequent increase in admissions. This has been alleviated by using patient pathways joining up acute and community care; and learning from the experiences of previous years, we managed our winter pressures and the opening of escalation beds more efficiently. Our annual flu vaccination

campaign was well-supported by staff, which again helped us to meet the challenges of the busiest season.

The success of our recruitment and training programme in the Philippines meant we were able to meet all our nursing vacancies, and these nurses have proved a most welcome and valuable addition to our workforce.

As a global digital exemplar, we have continued our work to improve working lives and our efficiency through digital solutions such as the rollout of Medic Bleep, and investment in the hardware, software and connectivity needed by our community staff.

The increase in activity brought financial challenges that were met with cost improvement programmes suggested and supported by colleagues across the Trust which put us in a good position at the end of the financial year. Nevertheless we welcome the Department of Health decision to write off the Trust's interim loans in the wake of the pandemic.

At the acute hospital site, we have celebrated the expansion and official opening of the acute assessment unit; first anniversary of the cardiac centre; the opening of a new accommodation block; and the 25th anniversary of the day surgery unit. Through a change in legislation, we were also able to transfer Newmarket Community Hospital to the Trust from NHS Property Services. This investment represents our commitment to a future that will see our Trust expand, develop and build ever greater links with our community.

As COVID-19 levels have become more stable we are starting to think about moving to a recovery phase. This is where normally you would aim to get things back to where they were before an incident occurred. However, we want to make sure we don't lose the good work we have achieved and just go back to 'how it was before'. We think this is an opportunity to learn collectively from our experiences and try to build an improved future as a Trust and as a workplace. We will use information and suggestions gathered from staff and stakeholders to inform and feed into multiple work streams, including the refresh of our future strategy, our COVID recovery plans, quality improvement, and our focus on wellbeing. It will even influence how we work in the plans for the new hospital.

Sheila Childerhouse
Chair
23 June 2020

Dr Stephen Dunn
Chief executive
23 June 2020

1.1.2 About our Trust – a summary

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

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

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

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

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

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

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

Our priorities are:

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

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

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

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

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

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

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

Our sites and services

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

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

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

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

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

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

From April 2020 the Trust provided primary care services at Glemsford Surgery via a sub-contracting arrangement of the existing General Medical Services (GMS) contract. Existing GP partners will continue to hold the GMS contract and as employees of the Trust will continue to provide primary care services on our behalf.

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

Our staff

We are one of the largest employers in Suffolk, employing 4,353 staff as of April 2020.

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

Our partners

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

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

Going concern

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

The control total for 2019/20 was achieved with an adjusted surplus of £102k reported.

During 2019/20 the Trust borrowed £17.9 million from DHSC. £8.2 million of this was for capital investment and £9.7 million for revenue support. It is probable that the Trust will require further borrowing in the next year to fund further capital projects.

The expectation is that income will be forthcoming from NHS England during 2020/21 in order to deliver the control total in the current climate. The Trust is forecasting to achieve a break even position in 2020/21 after taking into account the receipt of MRET and Provider Sustainability Funding.

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

1.2 Performance analysis

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

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

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

1.2.1 Performance management framework

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

Performance monitoring:

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

Governance framework:

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

Engagement and measurement:

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

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

The Trust has unconditional registration with the CQC with no enforcement action. During 2019/20 an application was made to extend the registration to incorporate an additional registered location for a primary care GP practice. This was approved in April 2020.

Following a comprehensive inspection in 2019 the Trust's overall rating was downgraded to 'requires improvement' as a consequence of a reduction in the ratings in four core services (medical care, surgery, maternity and outpatients) with another core area (urgent and emergency) maintaining the same rating as awarded in 2016. The community services (adults, children and young people and inpatient services) were all rated as 'good'.

Despite this disappointing assessment inspectors said staff: *"treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions they worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care"*.

A structured improvement plan to address all the findings of the report has been developed and WSFT is working in partnership with the West Suffolk CCG to implement an assurance framework to oversee its delivery.

Our services

We provide a range of patient services:

Indicators	2019/20	2018/19	2017/18	2016/17	2015/16
Inpatient planned	**3,475**	3,548	3,730	3,917	4,291
Inpatient non-planned	**32,374**	32,832	32,505	33,174	31,383
Day cases	**32,815**	31,696	30,824	30,105	29,392
Outpatient attendances (inc. ward attenders)	**271,316**	266,157	249,460	239,413	239,675
Outpatient procedures	**79,570**	79,404	82,880	87,474	106,032
Emergency department attendances	**78,822**	74,400	70,918	67,176	64,979

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

In 2019/20 our community teams in the west of Suffolk have received 55,000 new referrals, more than 270,000 face-to-face patient contacts, 48,000 telephone contacts and delivered 13,000 pieces of equipment.

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

Our financial performance

We achieved our financial plan. We recorded a surplus of £0.1 million for the year 2019/20 and £10.0 million deficit without provider sustainability funding (PSF), financial recovery fund (FRF) and marginal rate emergency tariff (MRET). Our planned control total was a £10.1 million deficit before receipt of PSF, FRF and MRET, impairments and the effect of donated assets.

	2019/20 £000s	2018/19 £000s	2017/18 £000s	2016/17 £000s	2015/16 £000s
Operating income	**283,173**	244,952	252,778	254,933	209,588
Operating costs	**(272,245)**	(242,770)	(245,906)	(251,016)	(213,994)
EBITDA * surplus/(deficit)	**10,928**	2,182	6,872	3,917	(4,406)
Depreciation, dividend and other costs	**(10,642)**	(8,226)	(7,159)	(6,961)	(5,861)
Fixed asset impairments**	**(7,903)**	(5,506)	0	(4,815)	(410)
Retained earnings	**(7,617)**	(11,550)	(287)	(7,859)	(10,677)

* EBITDA – measurement of earnings before interest, taxes, depreciation and amortisation

** Fixed asset impairments – these occur when the value of individual fixed assets reduces as a result of damage or obsolescence.

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

Highlights of the year

Looking back over this challenging year, there is much of which to be proud. In our comprehensive Care Quality Commission (CQC) report, the inspectors found that staff across the board: “treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions”, and that they “gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress.”

In a national survey, the CQC also reported that our emergency department is performing better than most in the country in several areas of urgent and emergency care. The WSFT matched the highest score in England for the availability of help from members of staff while patients were waiting in the emergency department, and also the overall score for waiting times. The survey scored us highly across categories including respect and dignity for our patients, their experience with doctors and nurses, and their overall care and treatment.

We were named one of 40 CHKS Top Hospitals for 2019 in the leading data-driven awards that have been running for 18 years. CHKS is a provider of healthcare intelligence and quality improvement services and the awards recognise hospitals that are safer for patients, more effective, more efficient and have lower mortality when compared with the performance of all hospitals in England, Wales and Northern Ireland.

The Royal College of Physicians’ national lung cancer audit reported that WSFT demonstrated a 40.1% one-year survival rate for this serious disease, a higher average rate than the regional and national rates of 34.6% and 37% respectively. This report also highlighted the importance of early diagnosis if people are to survive, and we are working with all our partners to facilitate this.

Our role was also acknowledged by our commissioners the West Suffolk Clinical Commissioning Group, in its achievement of the best cancer survival rates in the east of England. The figures from Public Health England showed that the one-year survival rate for patients in west Suffolk diagnosed with cancer is 74.9%, higher than any other CCG area in the east and above the national average of 73.3%. This survival rate has been increasing every year in west Suffolk.

The Macmillan Unit, which cares for people with cancer, has scored highly in its Macmillan Quality Environment Mark (MQEM) accreditation reassessment, maintaining an overall score of 4 (very good) and retaining its high standards. While the overall score has remained the same, some of the inspected areas have improved.

This year we have marked two significant milestones – the first anniversary of our cardiac centre; and 25 years since the opening of our day surgery unit. In one year, thousands of diagnostic tests have been run at the cardiac centre, and hundreds of cardiac patients have benefited from the procedures that can be performed on site. With its six operating theatres, the day surgery unit, which also houses the eye treatment centre, sees thousands of operations carried out every year for patients, most of whom go home on the same day.

Our state-of-the art acute assessment unit (AAU) is now fully completed and was officially opened by Jo Churchill, MP. The unit has transformed the way patients who do not need major emergency department care are observed, diagnosed and treated. We have expanded the ambulatory emergency care space and monitored bay, and assigned the unit a dedicated ambulance entrance. This allows us to provide better care while maximising our resources.

A change in legislation allowed the ownership of Newmarket Community Hospital to be transferred to the WSFT from NHS Property Services this year. The Trust provides a number of community services at the hospital, including an inpatient unit, X-Ray, outpatients department and community health team; and other providers including a GP surgery are based there. This helps us to offer joined-up, targeted care to the local population as a health provider in west Suffolk, and better manage the treatment pathway for patients between acute and community services.

The NHS workforce is, of course, our most valuable asset and we are committed to doing everything we can to support our staff wherever they work across Suffolk, to ensure they can provide care safely and efficiently, develop their skills, and know how much they are appreciated.

That is why we chose to offer every WSFT employee the chance to complete the annual NHS staff survey. We were pleased that the percentage of people responding increased by four per cent to 52%, which is also above the national average of 48%. There were many positive indicators for us, with a staff engagement score equal to the best in the country; and the morale and safety culture scores close to the highest national scores. Eight of the 11 themes in the survey had an improved score, three of those showing significant improvement, three were unchanged, and our community staff expressed the highest level of satisfaction across the Trust, a tribute to their leaders.

We have also acknowledged that 48 per cent of our colleagues chose not to respond, some reported worse experiences and significant challenges. We are using the findings alongside those of our CQC report to see what we can learn to bring lasting improvements throughout the Trust.

Our staff gave us a vote of confidence in the NHS Staff Friends and Family Test, with 92% of staff surveyed saying they would recommend the WSFT as a place to receive treatment, the seventh highest percentage in England. In addition, 79% said they would recommend it as a place to work, which is the tenth highest percentage in the country. These are both well above the national averages of 81% and 66% respectively.

As part of our commitment to staff welfare, we opened three new accommodation blocks at the Bury St Edmunds site. This £12.7 million scheme replaced the 40-year-old hospital residences with modern, five-storey buildings, providing 160 en-suite bedrooms complete with communal kitchen and living areas, including accessible facilities.

This year we made significant strides in managing the many nursing vacancies we had across the hospital, which was putting added pressure on staff to maintain quality, safe patient care. Our recruitment and subsequent in-house training programme for nurses from the Philippines has seen more than a hundred of these committed nurses joining our ward staff, meaning we are effectively fully staffed for nursing.

Our vacancy rate was also addressed by the launch of our imaginative, responsive #BeKnown recruitment campaign, which is a long-term project to attract people to apply to us in any professional capacity and ensure the work of the Trust is fully supported.

Our training and education team has been recognised in two national award schemes this year. Once again we achieved the highest score in the east of England for doctors' overall training satisfaction in acute trusts. The doctors at our Trust surveyed in the General Medical Council's (GMC) national training survey 2019 rated their overall satisfaction at 82%, a three per cent increase on last year.

A longstanding partnership between WSFT and West Suffolk College has seen us shortlisted for health and science apprenticeship provider of the year category in the FE Week and AELP AAC Apprenticeship Awards 2020. We were nominated by the college for our role in the joint training of senior healthcare support worker apprentices working at the hospital.

Our Putting You First citations and Shining Lights peer-nominated annual staff awards ensure that we can acknowledge those who go above and beyond even that which is demanded of everyone in the NHS. The efforts and achievements of these people are as always an inspiration to everyone at the Trust, and we appreciate those who take the time to put their colleagues forward.

Six staff that had been recognised in Shining Lights were nominated by us to attend a tea party for NHS staff at No 10 Downing Street, attended by the Prime Minister. We were also delighted that the retirement of our long-serving HR director and now Trust ambassador, Jan Bloomfield, was marked by her being given the lifetime achievement award at the Healthcare People Management Association excellence in healthcare human resource management awards.

Our overall CQC report highlighted the work we do to ensure we have an inclusive culture at the WSFT, with LGBTQ, BAME and disability fora all working to help us support every staff member and tackle discrimination at source.

1.2.3 Principal risks and uncertainties

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

Board assurance framework (BAF)

The BAF was regularly reviewed during 2019/20 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting strategic objectives. The BAF illustrates the escalation processes to the Board and its sub-committees when risk, financial and performance issues arise which require corrective action.

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

The principal risks identified in the BAF are reviewed by the Board of directors. The Board reviews the potential impacts of these risks and considers the robustness of the existing controls and future plans

to mitigate these. Assurance of the effectiveness of these controls and plans is also reviewed. A summary of the BAF is provided within the annual governance statement (section 2.5).

Incident reporting

The Trust's web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting of near misses, no harm and minor harm incidents. Reporting of these 'green' incidents is seen as a key driver for identification and management of risks to prevent more serious harm. The Board reviews this data routinely and recognises an increased incident reporting rate as a positive reflection of an open culture within the organisation which supports learning.

During 2019/20, a total of 8,008 patient safety incidents were reported (compared with 6,650 in 2018/19). The Trust has continued to build and strengthen the arrangements for managing serious incidents (SIs). The Board takes the lead on this process and reviews the management and investigation of SIs each month and learning from SIs as well as other patient safety data on a quarterly basis.

Effective risk and performance management

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

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

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

Mandatory service risk

The Trust's Board of directors was satisfied that:

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

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

Risk of any other non-compliance with licence

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

Contractors and suppliers

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

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

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

Additional disclosures required by the financial reporting manual (FReM)

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

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

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

Audit committee's review of the annual report and accounts

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

Social, community, anti-bribery and human rights issues

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

The Trust has applied policies during the financial year for:

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

The Trust is committed to the effective implementation of policies and procedures in respect of fraud and corruption as well as the Bribery Act. It also has a nominated local counter fraud specialist

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

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

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

In September 2019, the chief operating officer, as accountable emergency officer reported to NHS England and the CCG that the Trust had substantial compliance with core standards; the Trust had implemented a substantial, innovative and dynamic work plan as a result of a review and upgrade of EPRR.

The substantial compliance level indicated that the Trust had a number of core standards requiring improvement work in updating business continuity plans, and providing the documentation for formalised training of command and control staff. It should be noted that the delivery of EU Exit planning and the Covid-19 pandemic has delayed this work.

1.2.4 Future business plans

1.2.4.1 Integrated care system (ICS)

The Suffolk and North East Essex Integrated Care System (ICS) Board has been in place since early 2017. Leaders have agreed specific local priorities and deliverables, including the development of a small number of agreed, articulated and measurable higher ambitions for the partnership.

Our system delivery plan sets out the priority actions for the **West Suffolk Alliance** for 2020/21. We have agreed that as an alliance we will prioritise four areas of activity this year:

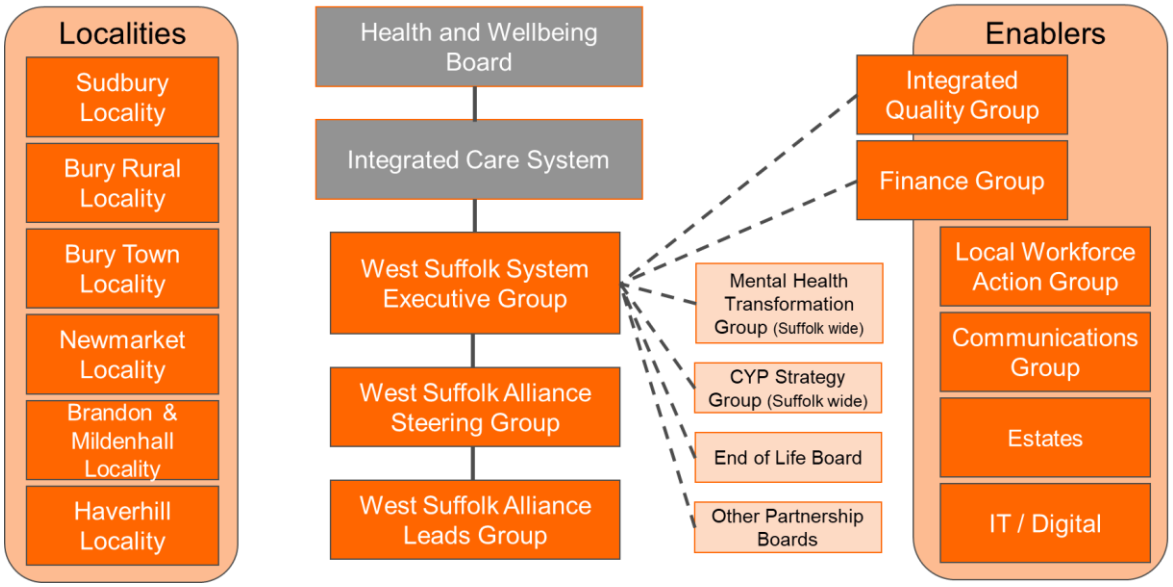
- The development of localities including integrated health and care teams
- The prevention and management of long-term conditions
- A co-ordinated responsive support approach
- An integrated response to demand management.

We believe that achievement in these areas will help us to meet our ambitions as an Alliance as set out in our strategy – “All about people and places”:

- Strengthening the **support for children and adults** to stay well and manage their mental and physical health and wellbeing within their communities
- **Focusing on individuals** and their needs and goals
- Changing both the way we **work together** and how services are configured
- Making effective **use of resources**.

To support the integrated care system (ICS) long-term plan each alliance has developed a comprehensive delivery plan, which is to be signed off and monitored via the system governance route as outlined below.

West Suffolk Alliance Governance – February 2020



It is recognised that the plan does not describe all the great work going on in West Suffolk, but rather gives us a focus on areas where we know we can only make progress by working together.

The plan also shows how we are contributing to the Suffolk and North East Essex integrated care system strategic plan and ultimately to the Suffolk Health and Wellbeing Board priorities. Chapters in the plan are:

- The key alliance programmes
- Our alliance enabling functions
- Our plans to improve how we manage long term conditions
- A bird's eye view of programmes
- Background information – locality maps, governance arrangements, monitoring framework.

We are building on two years of alliance working where we have **developed partnerships, trust and good relationships**. This has helped us to be clearer about where we can make progress together, what actions we need to be taking, and has broadened all our thinking about what might be possible. Our system executive group has accountability for the delivery of this plan, supported by the Alliance Steering Group.

The delivery plan is a live document, which means we will update and review it throughout the year. There are some sections that are less developed than others, as we have yet to fully agree our actions in these areas.

Key Alliance Programmes

Programme 1 - The development of localities including integrated health and care teams
Through working locally we are better able to listen to and work with people and communities. Together we can build on existing assets and opportunities and develop the sense of identity for those that live and service in our localities.

We know that traditionally a lack of integration has led to duplication of services, service gaps and poor communication between professionals and often frustration for people who use services. By working together we can improve health inequalities for residents in the west of Suffolk and people's experiences at critical points in their lives, for instance at the end of life. Integrating teams will give us

the opportunity to co-ordinate care more effectively around individual needs, provided more closely to people's homes.

Programme 2 – Prevention
Our population is increasing, and people are living longer. We want people in the west of Suffolk to live longer and spend those additional years in good health. Targeting prevention initiatives at population groups and areas with the worst health outcomes to ensure we improve their lives will help us tackle health inequalities.

Programme 3 - Developing a co-ordinated responsive support approach
Responsive support offers short-term, local, flexible, coordinated services for people to maximise independence during a time of changing health or social care needs. We want people to experience the right support, at the right time, to remain at home, based on an agreed care and support plan to achieve their goals.

Programme 4 - An integrated response to demand management
Health inequalities which drive demand are influenced by many factors, not just in health and care provision. It is important to understand and manage demand where possible so that we can provide services that meet the population need for health and care services.

Many of the actions to manage demand should also lead to people having more years without chronic ill-health. Focusing on shifting demand to prevention and early intervention, in a bid to reduce demand on acute and crisis services, will lead to better life outcomes and a more effective use of public resources.

Alliance partners

- West Suffolk NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Suffolk GP Federation
- Suffolk County Council
- Babergh District Council
- Mid Suffolk District Council
- West Suffolk District Council
- Care UK
- Healthwatch
- Suffolk Association of Independent Care Providers
- Abbeycroft Leisure
- Local pharmaceutical committee
- Allied Health Professionals Suffolk
- West Suffolk CCG
- St Nicholas Hospice Care
- Other system and county wide partners such as East of England Ambulance Services NHS Trust

1.2.4.2 Performance improvements and efficiency savings

During 2019-20 we have continued to operate our **joint transformation team** with West Suffolk CCG to support a comprehensive programme of efficiency and improvement work covering:

- Hospital
- System-wide integrated care
- System-wide planned care

These programmes have been reviewed and developed to take into account the planning assumptions and key deliverables from the NHS Long Term Plan. Examples are set out below but will

be subject to review in terms of timing and delivery taking account of the national and local response to Covid-19.

Primary care and community health

WSFT is a provider of both acute and community services. As a core member of the West Suffolk Alliance we play a key role in the delivery of the integrated care system (ICS) plan through the six localities of Sudbury, Bury Town, Bury Rural, Newmarket, Haverhill and Brandon and Mildenhall. The localities are broadly aligned with the local primary care networks (PCNs) and working together to deliver local and system priorities.

Over the next year we will be investing in community digital solutions as well as developing staff rostering capabilities to identify opportunities for improved productivity and efficiency. We are working closely with social care to implement joint management posts across locality teams to avoid duplication of assessment and service provision between community health and social care teams.

We are investing about £4 million during 2020/21 to update our digital infrastructure in our community settings. This programme will transform the way in which our community teams work through the latest infrastructure and equipment.

Our rapid intervention service is a joint service provided between the Trust and the East of England Ambulance Service which provides crisis response and admission avoidance from 8:00 am to 8.00 pm seven days a week. We also operate pathway one discharge services with access to community reablement within 48 hours.

Nationally, some healthcare providers are embarking on vertical integration models between primary and acute care to create resilience within their local healthcare systems and meet the rising complex needs of their population. We have been working with Glemsford Surgery since March 2019 to establish how the vertical integration model designed by Royal Wolverhampton Trust could work in west Suffolk. This work has culminated in the vertical integration business case based on integration with the surgery and acquisition of the surgery freehold and of Glemsford Services Ltd (the Pharmacy). It is anticipated that most of the benefits arising out of vertical integration will be quality improvements which will have a positive impact on population health and alliance working across the wider healthcare system.

Mental health

WSFT does not provide mental health services but is playing an active part in the system-wide transformation of mental health services. In September 2019, four models were presented to the Suffolk alliance partners. The high-level models were developed by priority groups to provide the foundation for the development of detailed pathways. The four models have been developed in line with the East and West Suffolk Mental Health and Emotional Wellbeing 10 Year Strategy 2019-29: #averydifferentconversation.

Detailed pathways are being developed that will sit behind the high-level models. The pathways are being visually mapped and capture the different ways people can access services and what the service journey will look like. This includes treatment and intervention, how people will step up to more intensive or specialist services, step down to less intensive and community services and transition in between services. The priority groups are leading on this piece of work with experts from across providers and settings. The programme has set clear deadlines for the completion of the detailed pathways (end of February 2020). Alongside the detailed pathways the alliance programme team which is made up of system experts who will provide all four priority groups with dedicated input to enable the following specialist models to be developed alongside the detailed pathways.

Learning disabilities and autism

WSFT provides paediatric community health services for the population of Suffolk. We are committed to working with our partners in the CCG, education and social care to deliver the highest quality care for the children and young people that we serve and meeting the requirements of the long-term plan. We are members of the Suffolk wide Children and Young Peoples Board. This board has

commissioned a full review of our integrated community paediatric services to ensure that they are appropriately resourced and meeting national and local requirements. This review is due to conclude in 2020 after which we will work to deliver identified actions.

Urgent and emergency care

WSFT is one of 14 pilot sites currently undertaking field testing for new emergency care standards. As such we are no longer monitoring and reporting against the four-hour standard. Data from the pilot indicates that we are one of the top performers against the new standards. As part of this programme we have remodelled our triage and assessment service to provide an enhanced rapid assessment and treatment service. This review has been focused on all ambulance arrivals and those walk-in patients who require it and is aimed at significantly reducing ambulance handover delays.

We have developed a predictive bed capacity model based upon historic patterns as well as predicted growth. This has enabled us to effectively plan our capacity requirements during 2019/20 but we recognise there have still been periods of extreme pressure. Through the following initiatives we are tackling:

- Length of stay (LOS): long stay Wednesdays, Red2Green, pathway one, trusted assessment, virtual ward, early intervention team (EIT), frailty unit
- Delayed transfers of care (DTOCs): formal DTOCs remain low at WSFT due to successful integrated working with our social care partners.
- Admission avoidance: we have implemented surgical same day emergency care during 2019/20 complementing our existing medical model. The collaboration between the Trust and East of England Ambulance Service NHS Trust (EEAST) to provide a rapid intervention vehicle has delivered an 80% non-conveyance rate to hospital. Our early intervention team operates a successful admission avoidance service from the emergency department (ED) and acute assessment unit (AAU).

During 2020/21 we will work to enhance these existing services and extend operating hours where necessary in line with this year's planning guidance.

Referral to treatment (RTT) and choice at 26 weeks

The Trust currently has a significant backlog of patients waiting over 18 weeks due to a shortfall in capacity and a lack of alternative providers locally. During the coming year we will work to improve compliance with the standard recognising the impact of COVID-19 on levels of activity. Additional financial support from the system will be required to deliver this level of improvement. We plan to have access to an additional inpatient operating theatre during 2020/21 and are developing business cases for the additional staff required in our most challenged specialties of trauma and orthopaedics, gynaecology, ophthalmology and general surgery. As part of this plan we will work to eliminate 52-week breaches.

We are keen to be able to offer choice at 26 weeks to our patients but have been unable to identify alternative providers within a reasonable travelling distance for our patients. We are working with NHS England and NHS Improvement to identify suitable alternative options.

Outpatient transformation

With West Suffolk Clinical Commissioning Group (WSCCG), we have embarked on a radical programme of outpatient transformation. This will be underpinned by digital innovation as part of our global digital exemplar programme. We will expand our videoconferencing pilot to ensure that we are able to offer virtual, telephone and video consultations across all services over a period of three years. Through the use of our patient portal and the implementation of the "Dr Dr" platform we will encourage and enable patient-initiated follow-up and reduce unnecessary face-to-face appointments. As part of this programme we will build on the success of our 100 day transformation programme from 2019/20 as part of our service level pathway redesign.

Cancer

WSFT works as part of the Suffolk and north east Essex cancer alliance to deliver system-wide transformation and improvements in cancer care. As a result of the work undertaken during 2019/20, we are making good progress against the delivery of the 62-day treatment standard and the 28-day faster diagnostic standard. We are working with the national intensive support team (IST) to ensure we have sufficient capacity and that our systems and processes for the management and tracking of patients on cancer pathways are optimised. This includes use of the pathway analyser tool to identify issues and prioritise areas for improvement. We are on track to deliver the four optimal timed pathways identified in the national planning guidance (lung, prostate, colorectal and oesophago-gastric) along with the stratified follow-up pathways for colorectal, prostate and breast cancer.

Productivity and efficiency

WSFT oversees the delivery of its productivity and efficiency schemes through its programme management office (PMO). The PMO regularly reviews data contained within the model hospital to identify efficiency opportunities. We have developed service level action plans following each getting it right first time (GIRFT) review and these are monitored through divisional governance programmes. We have worked with WSCCG to deliver the recommendations in the NHS Right Care programme and will continue this through our outpatient transformation plan.

We have implemented the intensive support team (IST) demand and capacity modelling tool across theatres, outpatients and diagnostic services. We have developed a dashboard to monitor theatre efficiencies and identify opportunities for improvement and have an outpatient dashboard currently in development. As a global digital exemplar we have used advanced hardware and software solutions to release time to care.

During 2020/21 we will be working to optimise existing solutions and maximise productivity and efficiency gains whilst also improving patient safety. We will invest about £4 million to improve the digital experience of our community teams. We have an embedded staff rostering tool for nursing and allied health professional teams and are implementing Allocate for rostering consultant and junior doctor teams.

Further details on **community transformation** as part of our Alliance working is provided in section 1.2.4.1.

Trust digital programme

The Trust was identified as a prestigious NHS global digital exemplar (GDE) after successfully bidding for a share of £100 million in funding to further improve the way technology is used to benefit patients.

Whilst the GDE funded part of the project has now completed, the Trust continues to drive towards the achievement of the Health Information Management System Society (HIMSS) accreditation at stage six. In 2020 this will introduce a clinically rich digital solution to maternity services alongside great clinical safety from closed loop medication and breast milk. The Trust will extend this provision when closed loop bloods goes live by the end of the financial year. During the coming year the Trust also plans to upgrade the whole electronic patient record (EPR) to the next version of the base software.

The digital programme is being delivered in four pillars although in 2019 these changed with Pillar 1 covering all developments across the West Suffolk Hospital; Pillar 2 the development of services across the wider health community; Pillar 3 is now focussed on digital services for community health services whilst Pillar 4 remains to deliver new digital infrastructure as a key enabler.

The Trust's vision for a digital future has not changed as it continues to be a primary enabler for the organisation's transformation goals, priorities and ambitions. Whilst the ambitions for the hospital are outlined above the other major work is a major migration project to take community health services into a cloud solution. Always available and widely accessible this programme of infrastructure work will enable improved outcomes and benefits designed to drive transformation and a fully integrated

patient journey. This realignment is linked to the Trust's organisational strategy, discussed with and countersigned by colleagues across the care economy and the wider public sector.

As a GDE, WSFT will work to remain an exemplar across our health and social care economy, seeking to engage with new and emerging digital solutions including smart apps, artificial intelligence, robotic process automation and voice technologies; with an increasing focus on integrated system working. Broadly the aims of the programme remain three-fold and continue to represent our five-year vision:

- **A transformation-led digital trust** – the programme will provide WSFT with a robust, fully digital platform which is paperless at point of care, resulting in operational efficiencies and improvements in quality of care. Real-time access to accurate information about patients and their care plans, and enterprise-wide scheduling will ensure seamless and safe handover of care across care settings. Evidence-based decision support such as early warnings for sepsis will optimise care and prevent illness. Efficiency improvements such as device integration will allow more time for direct patient care. Safer use of medications, blood and breast milk products through the closed loop process coupled with improved decision support and compliance will help deliver safer patient care. Many of these, including digital care pathways, early warnings, device integration and improved use of medication management, are already in place either in part or in full.
- **Supporting the goals of the integrated care system (ICS)** - the programme aims to support fully the goals of the emerging Suffolk and North East Essex ICS. A digitally mature Trust is essential for achieving the goals of the wider care community, and this is reflected in the level of investment planned for community health services to drive up digital maturity and enable both digital and service integration. A key enabler is the continued deployment of e-Care combined with wider system integration, such as the population health package being initiated in 2018 that will allow the Trust to provide an efficient and effective risk stratification approach to patient management. Suffolk has an older than average population, resulting in increasing demand for services versus affordability. By applying a risk stratification approach and targeting segments of the population such as those aged over 85, we can intervene in a way that abates demand. In parallel WSFT is extending the use of Health Information Exchange (HIE) right across the ICS and in 2020 across the boundary into the remainder of Essex. This will provide more authorised clinicians, from all parts of the health and care system, with access to relevant patient information - promoting informed clinical decisions about patient care.
- **Promoting our exemplar digital community** – working with our electronic patient record partners we will continue to build the model digital community across our ICS. We will contribute to the increased digital maturity of our partners, including neighbouring acute hospitals, community services, mental health, ambulance and social care by providing mentorship in all aspects of deployment, including leadership, informatics and intellectual property (IP) development. We will contribute to delivering digital maturity in both Cerner and non-Cerner sites alike through the sharing of experiences, approaches and solutions, defined as "blueprinting" with the GDE programme. We will achieve this goal through strengthening existing partnerships such as digitally advanced suppliers, and we will build new partnerships locally and internationally with other exemplar sites or IP development partnerships. If appropriate we may choose to widen the deployment of our Cerner solution across the ICS and even into service domains that are not covered by e-Care today.

Procurement

The Trust has a three-year procurement strategy that is being revised to support the Trust in achieving the following:

- Ensure all EU procurement directives are followed until 2021 and incorporate the new directives after that date
- Maintain level one of the Department of Health standards of procurement and work toward level two

- Implement a new contracts management system that achieves better visibility of contract spend and monitoring of key performance indicators ensuring compliance and benefits realisation are being achieved
- Compliance with Model Hospital and purchase price index and benchmarking model
- Working with NHS supply chain to standardise products to ensure our spending power is better utilised.

Work in collaboration with NHS supply chain, Crown Commercial Services and all the NHS procurement hubs to ensure best value is achieved. The Trust has a work plan that links with the NHS procurement hub, NHSI and NHS supply chain. We undertake benchmarking through the Department of Health spend comparison service to ensure pricing and commitments agreements offer the best opportunities for the Trust in line with its size and spend.

Agency rules

The two main clinical staff groups where agency staff are used are doctors and nurses. During 2019/20 we continued to use the agencies on the collaborative procurement partnership (CPP) framework preferred supplier list for nursing staff, and medical staff which was developed in conjunction with the East of England procurement hub. The CPP framework is audited by the procurement hub for framework compliance.

In 2019/20, as a result of a proactive planning process for the increased demand on services over the winter period, we have successfully reduced our reliance on agency nurses, bringing down the usage by 30%. This has also had the effect of increasing the competition between agencies and enabled us to improve our compliance with the cap rates by 50%. With regard to medical staff, the introduction of Allocate, “Locum on Duty” has increased the number of locum shifts that we are able to cover with our internal staff bank, reducing the use of agency doctors. The reduction in shifts put out to agencies has also improved our negotiating position for agencies to comply with capped rates.

In 2020 our work with the Cambridge and Peterborough cluster, supported by the East of England procurement hub will continue with a review of the CPP framework contract. The new contract will strengthen the rules that apply to agencies on the Framework and should result in an improved negotiating position for NHS Trusts using their services. The cluster will also look at establishing a tiered approach to working with the agencies which will stream line our booking processes and drive down agency rates.

Capital planning

The Trust has a five-year risk assessed capital strategy that focuses on addressing backlog issues and essential clinical developments in the acute and community sectors. This is further enhanced by an annual prioritisation process for the assessment of investment of capital resources. This is assessed via a multi-professional group using a forced risk ranking process, which assesses the benefits of investment against four criteria: compliance with the estate strategy; operational/clinical need; financial impact; and statutory compliance. The assessment ensures that:

- Risk priorities remain relevant and have not changed
- Any changes are incorporated from statute, alerts, NHS estates, etc.
- Any maintenance issues arising in the year are considered and incorporated.

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

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

The Trust has recently been awarded £14.9m subject to full business case approval for transformation of the Emergency Department. The Trust is aiming to complete this project in 2023.

A large part of the estate is more than 46 years old with an original design life of 30 years - this is reflected in the backlog maintenance costs, with the hospital identified as an outlier in the Model Hospital data. In the longer term, the Trust faces the challenge of providing a level of care appropriate to the 21st century, within ageing buildings, making it increasingly difficult to meet this challenge. In May 2019 the Standing Committee on Structural Safety (SCOSS) published an alert that advised that parts of the structure could be affected by shear failure with very limited warning. The alert related to a significant proportion of the hospital which is constructed of reinforced aerated autoclaved concrete (RAAC) planks, which have structural properties. There is no published information regarding the performance of RAAC planks past the intended design life. Since 2010 the Trust has had a Board approved strategy in place for the management of the hospital building structure. The emphasis of the strategy changed with the publication of the SCOSS alert and has resulted in an increase in investment and resources to ensure the building is as safe as possible. Future changes are likely to be significant and involve working with West Suffolk Borough Council to achieve the best outcome. The Council's planning framework sets out its policies and strategy for Bury St. Edmunds over the next 20 years and includes an option to build a new hospital on a 22 hectare site on the western edge of Bury St. Edmunds. A business case is being developed to look at the options for the future estate from which to deliver the services currently provided from the Hardwick Lane site. Some of the work has already been completed and was refreshed to take account of current thinking to inform the strategic outline business case which was approved by the Board in April 2020. This will be followed by the outline business case in April 2022 and full business case in September 2023.

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

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

Significant schemes planned for delivery in the period are:

- **Emergency Department (ED)** - the ED has a number of issues related to flow and effective decision making, in addition to buildings that are no longer functionally suitable. Visits from both the intensive support team and the CQC recommended a wholesale redevelopment of the department. Work on the business case to support the development has started and is due to be presented to the Board for approval in September 2020.

- **Theatre 1** - the plan for 2020/21 includes re-commissioning of theatre 1 which is currently used for storage and administration back to a general theatre and to provide an alternative bed storage area.

- **X-ray reporting room** - the current challenges posed by reporting demand, coupled with the inadequacies of the existing space require a redesign to provide a purpose-built reporting facility designed specifically for radiology reporting.

- **Structural issue** - following issue of the SCOSS alert a six-year plan to minimise the risk of structural failure has been developed and a significant proportion of the projects in the investment plan relate to this issue. Some are enablers (decant ward) and some relate directly to maintaining the structure. A bid for emergency capital has been submitted to NHSI for £77.5m to support the Trust with the delivery of this aspect of the investment plan. Resourcing of the development team has increased to take account of the requirements to maintain due

diligence records and ensure appropriate governance processes are in place, coupled with an increase in backlog projects that are required due to the aging infrastructure.

- **BMS/SMS Project** - the building management system (BMS) monitors and controls all of the hospital's engineering plant from boiler plant, heating and hot water systems, ventilation systems and standby generator plant to provide a safe and comfortable environment across the site for staff, patients and visitors. Another aspect of the system is the security management system (SMS) which controls access to restricted areas via the secure door entry system. Both these systems operate through the Schneider Continuum operating software, and the service provider has served notice that the system will no longer be supported with development or bug fixes. This has resulted in a project to upgrade both operating systems to the next generation of Schneider BMS and SMS which will enable us to continue to monitor and control the engineering services and security access to West Suffolk and Newmarket Community Hospitals. Allocation of resources will be subject to business case approval.

- **Backlog** - backlog projects are prioritised on an annual basis using risk-based methodology assessed by a range of disciplines (electrical, mechanical, architectural etc.). Key schemes covered during 2020/21 include:
    - Hot and cold water systems associated with legionella
    - Plant room refurbishment
    - Medical gas replacement
    - Main fire alarm system upgrade
    - External street lighting.

- **Feasibilities** - a range of feasibility studies will be undertaken to inform the scope of work for future investment schemes.

Sustainability

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

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

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

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

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

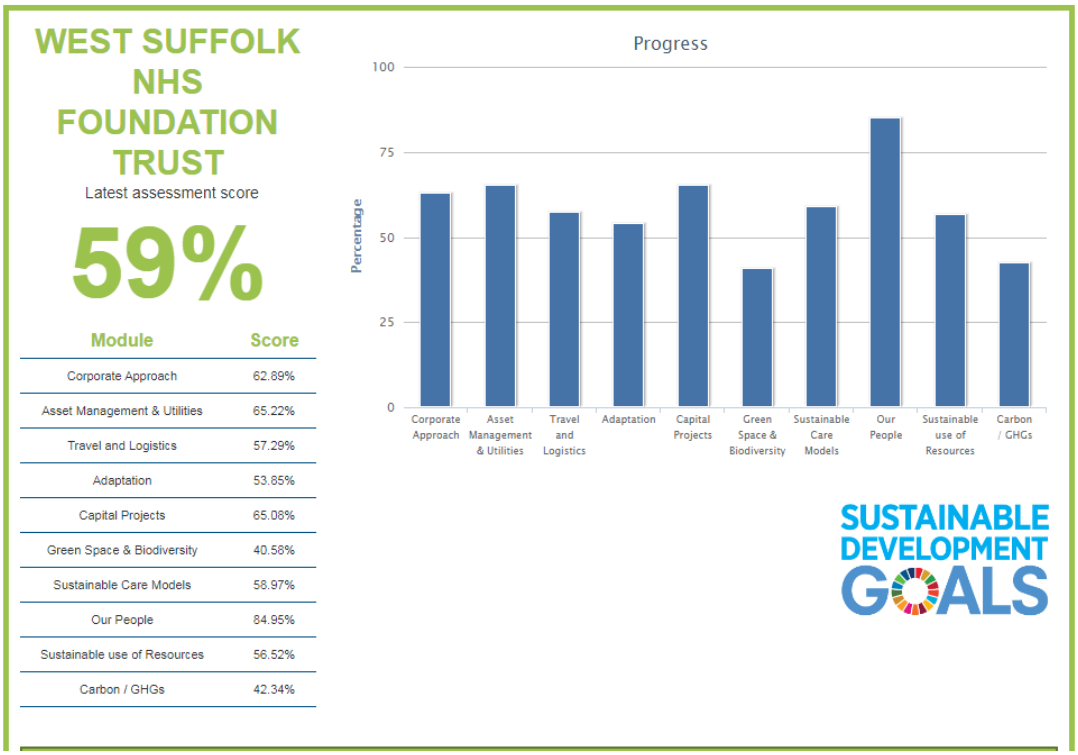
One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The board reviewed our SDMP in the last 12 months so our plans for a sustainable future are well-known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the sustainable development assessment tool (SDAT). The last time we updated the SDAT in December 2019, the score increased by 2% to 59%. The increase in score was a result of improved data collection and of completing actions in the annual plan.

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

In 2019 the sustainable development action plan focused on green space and biodiversity and carbon and greenhouse gases, as well as embedding a communications plan and ensuring that examples of good practice are collected and shared across the Trust.

Sustainable development assessment tool outcomes



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

Our organisation is clearly contributing to the following SDG:

SUSTAINABLE DEVELOPMENT GOALS

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

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

- West Suffolk Clinical Commissioning Group
- Suffolk Growth Programme Board
- East of England Procurement Hub
- Alliance partners – Suffolk County Council, Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, working closely with stakeholders such as the ambulance service, independent care providers, West Suffolk CCG and the wider voluntary sector, employers, education and business.

Energy

Resource		2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	22,915,910	25,103,388	24,605,975	26,394,446
	tCO_2e	4,789	5,322	5,217	5,596
Oil	Use (kWh)	2,823,162	1,075,600	0	0
	tCO_2e	895	351	0	0
Electricity	Use (kWh)	3,699,138	2,808,885	4,594,967	5,578,407
	tCO_2e	1,912	1,252	2,048	1,946
Total energy CO_2e		7,596	6,925	7,265	7,542
Total energy spend		£1,073,831	£1,047,805	£996,002	£1,040,358

Source of data 2015 – 2018 - ERIC returns to the Information Centre
2019-2020 data correct at 16/4/20

Photovoltaic Panels – energy generation

Energy output PV panels	2018/19	2019/20
Quince House	6,381	10,741
Accommodation (Beeton, Bloomfield and Clarke)	-	23,693

2019-2020 data correct at 16/4/20

The Trust joined the feed-in-tariff (FIT) scheme and receives an income per kWh generated from the photovoltaic panels placed on Beeton, Bloomfield and Clarke House accommodation. Since September 2019 this has generated an income of £371 from this scheme.

Combined heat and power (CHP) unit

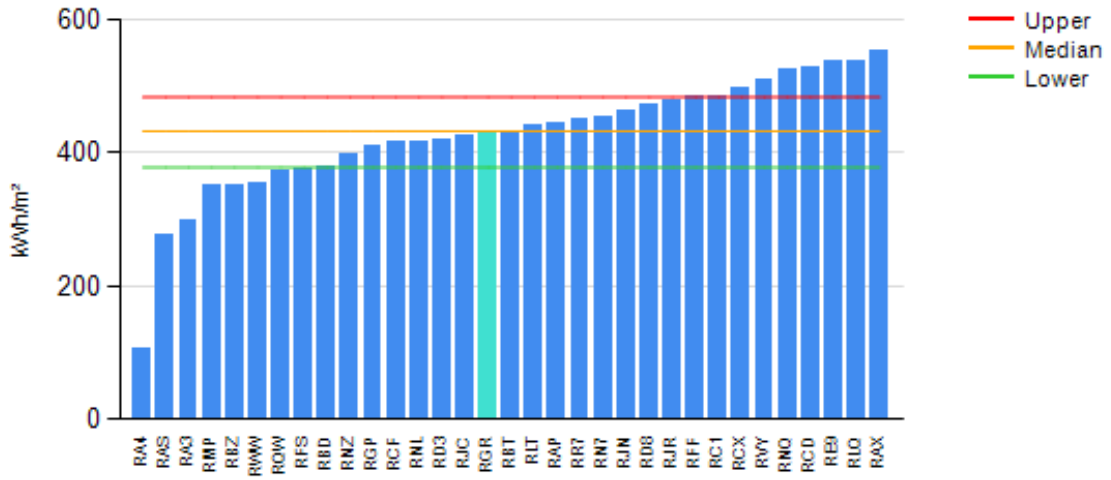
	2016/17	2017/18	2018/2019	2019/2020
Fossil energy **input** to the CHP system (kWh)	16,998,484	15,942,272	14,514,629	17,176,672
Electrical energy **output** of CHP system (kWh)	5,656,174	5,262,992	5,144,790	5,501,661
Thermal energy **output** of CHP system (kWh)	6,448,000	2,700,000*	*4,160030	7,272,380

*Note the CHP heat meter was faulty for three months leading to a lower than expected reading.
2019-2020 data correct at 16/4/20

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

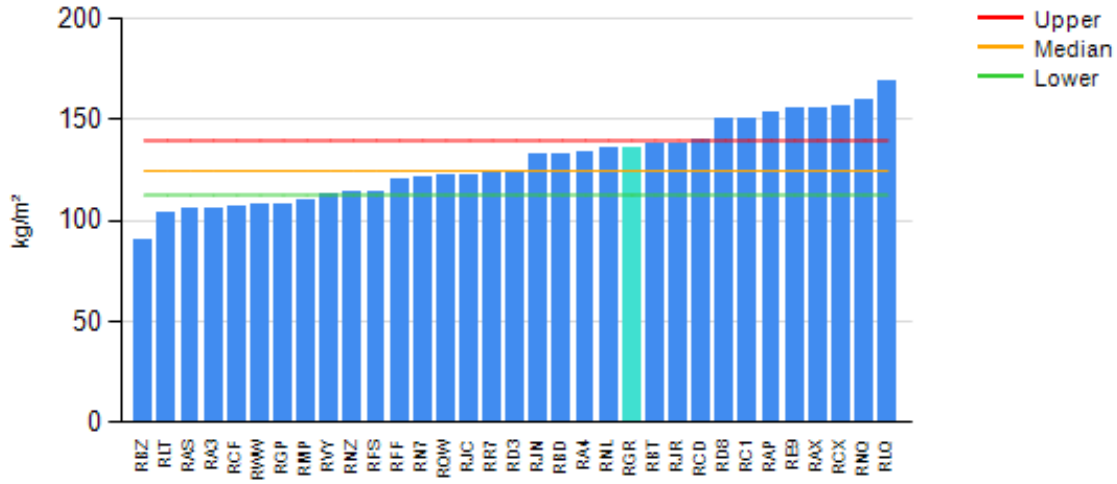
- Continued operation of the site's combined heat and power (CHP) unit 24/7
- Continuing to install improved energy efficient engineering plant under the Trust backlog programme
- Continued use of personal computer (PC) power saver system which turns off PCs safely overnight if left on.

Electrical energy consumed per occupied floor area (small acute)



Source: NHS Digital

CO2 emissions per occupied floor area (small acute)



Source: NHS Digital

Paper

Paper		2016/17	2017/18	2018/19	2019/20
Volume used	Tonnes	48	45	44	42
Carbon emissions	tCO_2e	46	43	41	40

Travel

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

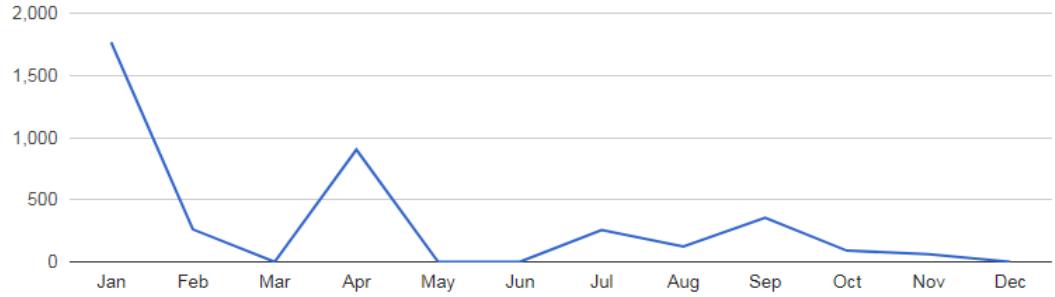
Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population,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

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

Waste, recycling and re-use

The Trust continues to use and promote the Warp It reuse portal allows colleagues to advertise surplus furniture and stationery for reuse within the Trust. The Warp It group has grown to 292 members and to date, in addition to avoided re-procurement costs of £26,903, has avoided 2,805kg of waste and saved 10,751kg CO2e emissions.

Warp It savings 2019 (£s)



WEEE waste

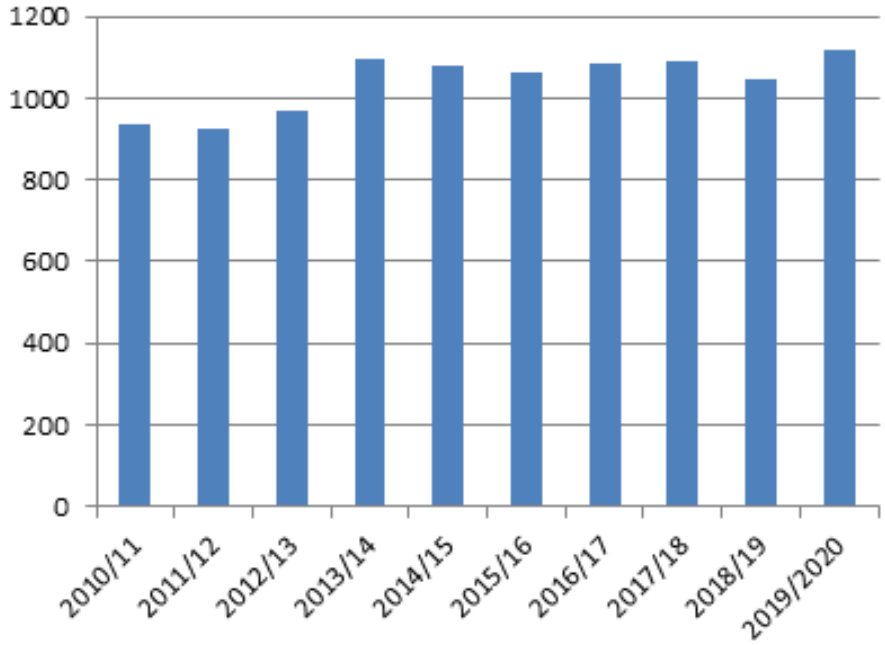
In 2019 the Trust changed the contractor for the collection of waste electronic and electrical equipment (WEEE) to CDL. This service is now free of charge, which represented a total cost saving of £3,372.86 compared to the 2018/19 financial year. From the 10.6 tonnes of WEEE (including batteries) collected by CDL, almost two tonnes were recovered to be reused and the rest was recycled.

Waste (total clinical and non-clinical)

Waste		2016/17	2017/18	2018/19	2019/20
Recycling	(tonnes)	231.96	254.14	228.28	246.1
	tCO_2e	4.87	5.53	4.88	5.36
Other recovery	(tonnes)	398.76	393.94	364.94	423.74
	tCO_2e	8.37	8.57	7.81	9.22
High temp disposal	(tonnes)	455.06	444.10	452.76	445.54
	tCO_2e	100.11	97.70	99.7	98.02
Landfill	(tonnes)	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00
Total waste (tonnes)		1085.78	1092.18	1045.98	1,115.38
% Recycled or re-used		21%	23%	21.8%	22%
Total waste tCO_2e		113.36	111.80	112.39	112.60

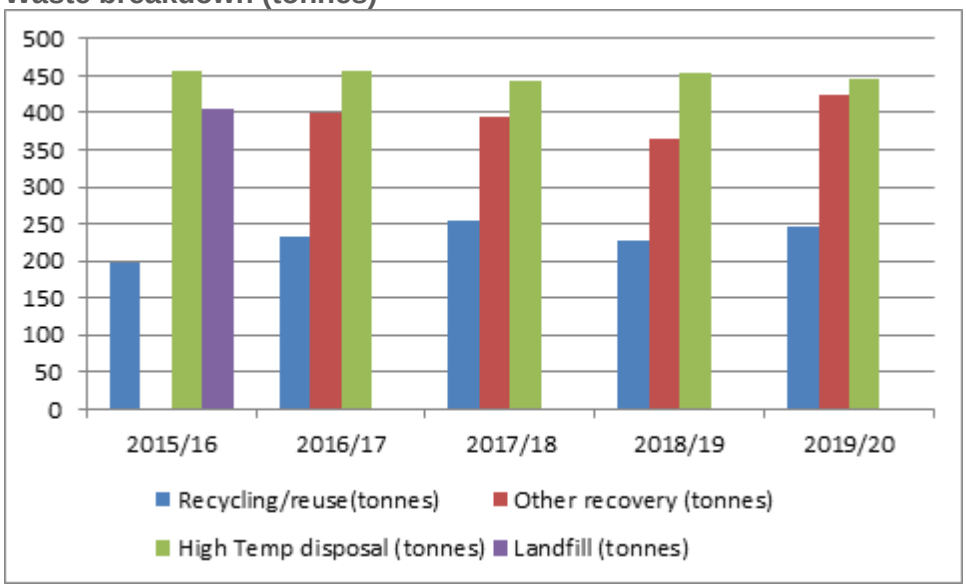
Data source – quarterly waste returns, data correct at April 2020

Total waste (tonnes)



Data source – quarterly waste returns, data correct at April 2020

Waste breakdown (tonnes)



Data source – quarterly waste returns, data correct at April 2020

From April 2019 to March 2020 approximately 5.5 tonnes of plastic from the Trust has been recycled. In 2019- 2020, 22% of total waste was recycled.

Food waste trial

During a food waste trial run between 31 January and 31 March, 2.4 tonnes of food waste and coffee grounds were collected by West Suffolk Council from the hospital's main kitchen. The total cost of collection and transport to the anaerobic digestion facilities was £210 (exc. VAT). This waste was diverted from the domestic waste stream, representing a total of £168 (exc. VAT) in cost savings. The two anaerobic digestion facilities that accept the food waste are in Kettering and March.

Finite resource use – water

Water		2016/17	2017/18	2018/19	2019/20*
Mains water	m^3	71,300	96,682	121,030	111,001
	tCO_2e	65	88	110	101
Water and sewage spend	£	£148,800	£205,547	£263,086	£189,056

Source of data: ERIC returns to the Information Centre
2018/19 data has been updated to reflect the final reported position. 2019/20 covers 10-month period (April 2019 to January 2020). The full-year estimated spend for 2019/20 is £285,833.

Other initiatives

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

- **Pharmacy department:** participates in the GSK inhaler recycling scheme and encourages all wards, and patients, to return inhalers to pharmacy (used or unused) for assessment and appropriate recycling. We also accept direct patient returns of inhalers to process via this scheme, and are looking to work with the respiratory physiotherapists to encourage them to return patients inhalers to the hospital for recycling.
- **Works contractors:** undertake the following to achieve sustainable outputs on smaller construction projects. Minor works and refurbishment projects - small scale: contractors undertaking minor works and small-scale refurbishment projects indicate that they are implementing sustainable construction. Major contractors reduce waste on construction sites which must be measurable in order to demonstrate compliance with key performance indicators both internally and externally.
- **Catering department:** has already moved to paper straws and wooden stirrers and continues to liaise with suppliers regarding alternative recyclable food packaging and coffee cups. To date, although alternatives are available they bring a cost pressure of up to 10p per item which would have to be passed on to the customer. Also, current waste streams do not necessarily support recycling of these alternatives, for example there is no route for biodegradable packaging or waste coffee cups and introducing further waste streams will increase disposal costs.
- **Installing LED lighting:** was identified as an important step towards achieving energy efficiency and it is planned to have 100% LED lighting across the site. This project is now in its second phase. The project has been financed by a combination of Salix and NHS energy efficiency funding.
- **Smart Scan luminaires:** are being used and further savings can be achieved by dimming down if there is natural light contribution and turning off if the space is unoccupied. This technology provides continuous monitoring of the power usage of the luminaires and also the detection of any faults. During ongoing routine maintenance the estates team replace lighting with LED alternatives.

The electricity used on the hospital site comes from different sources, 43.85% from an external supplier, 55.75% from the onsite combined heat and power plant and 0.4% renewable energy generated on site from photovoltaic panels. The Energy policy commits the Trust to increasing the percentage of low carbon and renewable energy sources in the electricity mix purchased from the electricity supplier. Currently 83.8% of the electricity supplied by EDF Energy is low carbon, however of this only 11.73% is from renewable sources.

2020–21

Informed by national guidance, the sustainable development management plan will be updated and reviewed and become the green plan. The associated action plan will focus on the areas outlined in section 6 of the NHS contract and updated service conditions, including:

- Proposals to meet reductions in business and fleet air pollutant emissions
- A review of business travel reimbursement for domestic flights in England, Scotland and Wales
- Sign up to the plastics pledge and continue to work with suppliers to identify viable alternatives to single use plastic catering items
- Where possible extend to wards e.g. straws, plastic cups, cotton buds
- Increase the percentage of renewable electricity in the fuel mix
- Reducing the overall carbon impact of all inhalers dispensed at pharmacy
- Review the opportunity to reduce the proportion of desflurane to sevoflurane used in surgery to less than 20% by volume
- Assess the potential to reduce unnecessary emissions of nitrous oxide to the atmosphere
- Replacing lighting with LED alternatives – including at Newmarket Community Hospital

Please note: The Trust response to the Covid-19 pandemic has meant that some sustainability initiatives have been delayed or suspended, such as the second phase of the LED project and the wider introduction of plastic recycling. These projects will be revisited as soon as possible.

2. Accountability report

2.1 Governors' report

2.1.1 Responsibilities

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

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

2.1.2 Composition

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

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

Peter Alder
Mary Allan
Florence Bevan
June Carpenter
Justine Corney
Jayne Gilbert
Robin Howe
Gordon McKay
Barry Moult
Jayne Neal
Adrian Osborne
Joe Pajak
Jane Skinner
Liz Steele (lead governor)

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

Peta Cook
Javed Imam
Amanda Keighley
Garry Sharp[(1)]
Vinod Shenoy[(2)]
Martin Wood

[(1)] Resigned from council of governors July 2019
[(2)] Appointed to council of governors November 2019

Partner governors – nominated by partner organisations of WSFT

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

Governor attendance at council of governors' meetings 2019/20

There were five formal meetings of the council of governors: 13 May 2019, 6 August 2019, 17 September 2019 (Annual Members Meeting), 13 November 2019, 11 February 2020, with the following governor attendance:

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

[1] Resigned from council of governors July 2019
[2] Appointed to council of governors November 2019

In attendance at these meetings were: Sheila Childerhouse, chair (5) Dr Richard Davies, non-executive director (5); Craig Black, executive director of resources (1); Dr Stephen Dunn, chief executive (3); Angus Eaton, non-executive director (3); Dr Nick Jenkins, executive medical director (1); Gary Norgate, non-executive director (5); Louisa Pepper, non-executive director (5); Jeremy Over, executive director of workforce and communications - appointed 1 November 2019 (1); Rowan Procter, executive chief nurse (2); Alan Rose, non-executive director (5).

2.1.3 Register of interests

All governors are asked to declare any interests on the register at the time of their appointment or election. This register is reviewed and maintained by the trust secretary. The register is available for inspection by members of the public. Anyone who wishes to see the register should contact the trust secretary at the following address:

Trust secretary, Foundation Trust Office, West Suffolk NHS Foundation Trust, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ.

2.1.4 Governors and directors working together

Governors and directors have developed a professional working relationship, on both a formal and informal basis. A number of governors attend and observe the monthly Board of directors meetings. This gives them an insight into and understanding of the performance of the Board, particularly from a quality and finance perspective and provides an insight into the role and performance of the non-executive directors (NEDs).

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

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

A joint council of governors and Board workshop took place in January 2020 to consider the draft CQC report. A workshop scheduled for April 2020 to review the Trust's strategy and operational plan was cancelled due to Covid-19.

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

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

Governors take part in the weekly quality walkabouts. These are led by the chief executive or chair and also include an executive director or NED. This gives governors a greater understanding of services across the organisation, as well as providing an opportunity for them to interact with patients, staff and directors. Governors also take part in regular environmental walkabouts and area observations. The environmental walkabouts support department managers in ensuring that the Trust's corporate identity and values are represented accurately. For area observations a governor discreetly sits in an outpatient area for an hour and observes the environment, general atmosphere, staff interactions and anything else they feel is enhancing or adversely affecting patient experience. This information is fed back to the manager and an action plan monitored through the patient and carer experience group. In line with social distancing requirements these activities have been paused during the Covid-19 response.

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

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

- Governor training day with external trainer – governance, assurance and the role of governors; quality, accountability and relationship with the Board; effective questioning and challenge; governor feedback and action planning.
- Governors were invited to attend quality presentations to the Trust's quality and risk committee on 28 June 2019, 27 September 2019 and 13 December 2019.

2.1.5 Membership

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

Public membership

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

Patients and members of the public who reside in the following areas are eligible to join our public constituency:

Babergh:	Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
East Suffolk:	Aldeburgh, Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Gunton & Corton, Grundisburgh, Hacheston, Halesworth, Harbour, Kesgrave East, Kesgrave West, Kessingland Kirkley, Kirton, Leiston, Lothingland Martlesham, Melton, Nacton & Purdis Farm, Normanston, Orford & Eyke, Oulton, Oulton Broad, Pakefield, Peasenhall & Yoxford, Rendlesham, Saxmundham, Southwold & Reydon, St Margaret's, The Saints, The Trimleys, Tower, Wainford, Wenhaston & Westleton, Whitton, Wickham Market, Woodbridge Worlingham, Wrentham.
Ipswich	Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmswell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddenham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hessett, Wetheringsett, Woolpit, Worlingworth.

South Norfolk:	Bressingham and Burston, Diss and Roydon
West Suffolk:	Abbeygate, All Saints, Bardwell, Barningham, Barrow, Brandon East, Brandon West, Cavendish, Chedburgh, Clare, Eastgate, Eriswell & the Rows, Exning, Fornham, Great Barton, Great Heath, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Iceni, Ixworth, Lakenheath, Kedington, Manor, Marham Park, Market, Minden, Moreton Hall, Northgate, Pakenham, Risby, Red Lodge, Risbygate, Rougham, Southgate, St Marys, Severals, South, St Olaves, Stanton, Westgate, Wickhambrook, Withersfield

Staff membership

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

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

Membership numbers

At 31 March 2020 there were 6,296 public members and 5,196 staff members.

Membership strategy

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

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

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

A number of engagement activities have been paused as a result of the social distancing requirements in response to Covid-19. A greater focus is being given to electronic communication and engagement methods.

Criteria	Current March 2020	Target (Mar 2021)
1. Achievement of the recruitment target: a. Total number of public members b. Staff opting out of membership	 **6,296** **<1%**	 6,000 <1%
2. Achieve a representative membership for our membership area, priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	 **1,212** **20%**	 1,250 40%
3. An engaged membership measured by: a. number of member events held April 2019 - March 2021 b. member attendance – total all events c. annual members' meeting attendance (each year)	 **2** **362**[1] **295 (2019)**	 3 [2] 400[1 and 2] 200

[1] Includes people attending annual members' meeting
[2] Figures have been adjusted due to Covid-19

During the past year the Trust held two special interest events on services provided by WSFT. These have proved extremely popular with a total of 362 people attending the two events. These events have also been used to provide feedback on the services provided by WSFT.

Contact procedures for members

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

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

2.1.6 Nominations committee

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

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

In June 2019 the nominations committee reviewed the feedback from the appraisals of the NEDs and key messages that would be fed back to each individual.

In October 2019 the committee agreed to recommend to the council of governors that two NEDs, whose first terms of office would end in February and March 2020, should be offered a further three-year term of office. This recommendation was approved by the council of governors in November 2019. The committee also reviewed the NHS England and Improvement guidance "Framework for conducting annual appraisals of NHS provider chairs"; "Framework for remuneration of chairs and

non-executive directors" and "The role of the NHS provider chair: a framework for development". Its recommended actions to be taken in response to these was approved by the council of governors.

In January 2020 the committee agreed to recommend to the council of governors that a NED who had already completed two terms of office and a further one-year extension should not be offered a further one-year term. The committee agreed a process for the recruitment of a NED to this position which would become vacant in September 2020. At this meeting the committee also agreed a recommendation to the council of governors for amendments to the appraisal form, job description and person specification for the chair and NEDs. They also reviewed and agreed a recommendation to the council of governors for an increase in remuneration for the chair and NEDs. These recommendations were approved at a closed session of the council of governors in February 2020.

Attendance at nominations committee meetings 2019/20

Name	Title	Attendance (out of three)
Sheila Childerhouse (chair)	Chair	3
Justine Corney	Public governor	2
Sara Mildmay-White	Partner governor	3
Barry Moult	Public governor	2
Jane Skinner	Public governor	3
Liz Steele	Public governor (lead governor from 1/12/18)	3
Martin Wood	Staff governor	2

Meeting dates: 5 June 2019; 18 October 2019; 22 January 2020

2.2 Directors' report

2.2.1 Responsibilities

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

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

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

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

2.2.2 Composition

(a) Non-executive directors

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

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

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

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

Dr Richard Davies – NED
(Appointed: from 1 March 2017 until 28 February 2020; reappointed 1 March 2020 until 28 February 2023)

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

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

Independent director – yes (see Note 1)

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

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

Angus is a qualified lawyer with wide executive and board experience. Currently, he is group chief risk officer of Hasting plc. His previous experience is across the legal, insurance and fund management sectors in various roles, including MD consumer legal services and chief risk officer at Slater and Gordon, UK strategy and transformation director at Aviva and a board director of Aviva's Turkish Life joint venture; MD Aviva's UK commercial general insurance business; chief risk officer, Aviva's UK and Ireland general insurance business; Aviva Group regulatory and operational risk director and group legal director.

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

Mr Gary Norgate – NED and senior independent director
(Appointed: from 1 September 2013 until 31 August 2016; reappointed 1 September 2016 until 31 August 2019; reappointed 1 September until 31 August 2020. Stepped down as NED on 31 May 2020)

Areas of special interest/responsibility: chair of scrutiny committee and charitable funds committee; senior independent director focusing on freedom to speak up and whistleblowing; non-executive lead for the future estate strategy; member of remuneration committee, audit committee, digital programme board, clinical excellence and discretionary awards committee; and lead NED for digital and procurement.

With a doctorate in corporate governance, Gary has a special interest in board effectiveness and the management of change. He also has a special interest in ensuring WSFT maintains and fully exploits its status as a global digital exemplar, harnessing the power of digitisation to drive sustainable improvements in both patient and commercial outcomes. Gary was, until November 2019, a senior executive at BT plc performing global commercial and transformation leadership roles. He has previous NED experience with Cambridge Community Services NHS Trust and Suffolk Mental Health Partnership NHS Trust.

Independent director – yes (see Note 2)

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

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

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

Louisa is a trustee of Suffolk Community Foundation.

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

Mr Alan Rose – NED and deputy chair
(Appointed: from 1 April 2017 until 31 March 2020; reappointed 1 April 2020 until 31 March 2023)

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

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

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

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

Note 2
Gary Norgate was appointed following a competitive recruitment process on 1 September 2013 for a three year term. Following review of performance and recommendations by the nominations committee the council of governors approved extension of the term on 9 February 2016 and 12 February 2019. In accordance with the code of governance, and recognising that the individual would have served in the role for six years, the second reappointment was for a period of one year.

(b) Executive directors

Mrs Helen Beck – chief operating officer

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

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

Helen has 35 years' experience in the NHS and is a registered general nurse with a diploma in theatre nursing.

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

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

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

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

Craig has 28 years' experience within the NHS. Having graduated from the national financial management training scheme he has worked in health authorities, a community and mental healthcare trust and a primary care trust, as well as a number of acute hospitals in Surrey and East Anglia. He is a CQC executive reviewer.

Dr Stephen Dunn CBE – chief executive

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

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

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

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

Stephen was appointed a Commander of the Order of the British Empire (CBE) in the New Year's Honours 2019.

Dr Nick Jenkins - executive medical director

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

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

Nick was on the NHS Leadership Academy executive fast track programme. He is a CQC executive reviewer and a non-executive director of Unity Schools Partnership Trust.

Mrs Rowan Procter – executive chief nurse

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

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

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

Rowan was appointed director of care and support at the Orwell Housing Association and took up this post on 1 June 2020.

Mr Jeremy Over – executive director of workforce and communications*
(appointed 4 November 2019)

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

Prior to joining the Trust in November 2019 Jeremy was director of workforce at Norfolk and Norwich University Hospitals NHS Foundation Trust. He has twenty years' experience within people management and development roles in the NHS. He also held an executive role at the University College London Hospitals NHS Foundation Trust.

Jeremy is a fellow of the Chartered Institute of Personnel and Development and former chair of NHS Employers medical workforce forum.

* Non-voting director

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

2.2.3 Register of interests

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

2.2.4 Appointment of chair and non-executive directors

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

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

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

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

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

2.2.5 Evaluation of the Board of directors' performance

Attendance at Board of directors meetings 2019/20

Name	Title	Attendance (out of 10)
Helen Beck	Chief operating officer	10
Craig Black	Executive director of resources	9
Sheila Childerhouse	Chair	9
Richard Davies	Non-executive director	9
Stephen Dunn	Chief executive	9
Angus Eaton	Non-executive director	8
Nick Jenkins	Executive medical director	10
Gary Norgate	Non-executive director	10
Jeremy Over[(a)]	Executive director of workforce and communications	(4of 4)
Louisa Pepper	Non-executive director	10
Rowan Procter	Executive chief nurse	9
Alan Rose	Non-executive director	10

[(a)] Jeremy Over was appointed as executive director of workforce and communications from 4 November 2019

Meeting dates
26 April 2019, 24 May 2019, 28 June 2019, 26 July 2019, 27 September 2019, 1 November 2019, 29 November 2019, 31 January 2020, 28 February 2020, 27 March 2020

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

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

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

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

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

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

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

2.2.6 Audit committee

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

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

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

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

As part of the approval of the annual external audit plan, the external audit process is subject to review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The audit committee meets with the external auditor without officers present on an annual basis. The council of governors reappointed the external auditors on 8 February 2017 for the financial years 2017/18 to 2019/20 and subsequently activated an option to extend BDO's appointment for one further year until 2020/21. The cost of statutory services for the 2019/20 financial year was £54,000 (2018/19; £59,000). The reduced fee for 2019/20 reflects removal of the audit requirements for annual quality report.

Non-audit work may be performed by the external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For all such assignments the audit committee will be advised, which will ensure that objectivity and independence is safeguarded. No such work was undertaken in 2019/20.

Internal audit

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

System of internal control

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

Attendance at audit committee meetings

Name	Title	Attendance (out of 5)
Sheila Childerhouse	Trust chair	4
Richard Davies	Non-executive director	5
Angus Eaton	Non-executive director (audit committee chair)	4
Louisa Pepper	Non-executive director	5
Gary Norgate	Non-executive director	5
Alan Rose	Non-executive director	4

Meeting dates: 26 April 2019, 23 May 2019, 26 July 2019, 1 November 2019 and 31 January 2020

2.2.7 Well-led framework

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

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

The Board of directors reviews the arrangements in place to deliver quality as part of the annual governance review it undertakes. This includes a review of relevant assurances within the board assurance framework. During 2019/20 the Board used the 'well-led' framework published by NHSI and CQC as the basis of this review. Based on the internal work undertaken and the CQC's well-led rating of WSFT as requires improvement, an external developmental review of their leadership and governance using the well-led framework will take place in 2020/21.

2.2.8 Details of consultation

In November 2018, we consulted the local community on our proposals to develop the Church Field Road site in Sudbury for up to 235 homes. We reviewed all the comments that were made and in response we introduced some changes to the development. The main change was the inclusion of a care home, with up to 60 rooms, on the part of the site closest to the community health centre on Church Field Road. We also proposed reducing the housing density, so the homes would have more space around them, and introduce some bungalows and smaller homes. The two entrances into the site will remain in the same location on Church Field Road.

We consulted with members of staff and the public about further proposed changes between 10 and 23 September 2019. This was through a limited focus consultation with members of the public made aware of the event via leaflets and a web page which contained the details of revised plans; this went live on 10 September 2019. Local councillors, members of the local parish council and campaign group Sudbury WATCH were made aware. 146 people responded during the consultation.

In summary, and in line with the November 2018 public consultation, comments mainly related to:

- Transport/traffic impact
- Lack of infrastructure/facilities (schools, shops)
- Loss of NHS land (need a small hospital, medical centre not accepting any new patients)
- Loss of green space
- Loss of employment land / principle of any development on the land.

The masterplan and submission documents were adjusted to show where consideration was given to take account of comments made during the consultation. The planning application was submitted on 12 March 2020.

Public engagement continued throughout the year through our patient user group, VOICE, which has increased its membership of patients, family carers and relatives. We have also made plans to introduce a paediatric user group in our community, which is recruiting parents and children to shape future services.

Some of the projects the VOICE group has been involved in during the year include:

- The patient profile
- Patient record e-portal
- Improving end of life care for patients and their loved ones
- Improving the hospital discharge experience
- Developing quality patient stories
- Experience of care week
- Emergency department professional standards
- Improving our chaplaincy services, including reviewing its inclusiveness.

The group also plans to work with frontline staff to understand their own experiences of the organisation, including supporting development suggestions relating to improved experience of care.

2.2.9 Other disclosures

Companies act disclosures

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

- Important events since the end of the financial year affecting WSFT
- An indication of likely future developments
- Actions taken in the financial year to provide employees systematically with information on matters of concern to them
- Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Actions taken in the financial year to encourage the involvement of employees in WSFT's performance
- Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of WSFT.

Cost allocation

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Income statement

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income that the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

Political donations

The Trust did not make any political donations during 2019/20.

Better payments practice code

The Trust is a signatory to the better payments practice code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust has paid £58 of interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2019/20 (2018/19 £1,942).

	2019/20		2018/19	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	59,655	145,747	56,710	139,168
Total non-NHS trade invoices paid within target	24,787	86,932	28,527	76,513
Non-NHS trade invoices paid within target (%)	**41.6%**	**59.7%**	**50.3%**	**55.0%**
Total NHS trade invoices paid in the year	2,035	45,966	1,794	49,332
Total NHS trade invoices paid within target	503	32,919	661	35,486
NHS trade invoices paid within target (%)	**24.7%**	**71.6%**	**36.8%**	**72.7%**

Statement regarding the annual report and accounts

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

Dr Stephen Dunn
Chief executive
23 June 2020

2.3 Foundation trust code of governance compliance

The Trust has applied the principles of the NHS foundation trust code of governance on a comply or explain basis. The NHS foundation trust code of governance, most recently revised in July 2014, is based on the principles of the UK corporate governance code issued in 2012.

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

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

2.4 NHS Improvement's single oversight framework

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

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

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

Segmentation

The Trust has been placed in segment 3, the third best category. This segmentation information is the Trust's position at 30 April 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2019/20 scores				2018/19 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial efficiency	I&E margin	2	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	1	4	4	4	1	1	1	1
	Agency spend	1	1	1	1	1	1	1	1
Overall scoring		**3**	**3**	**3**	**3**	3	3	3	3

2.5 Statement of accounting officer's responsibilities

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

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy
- prepare the financial statements on a going concern basis **and disclose any material uncertainties over going concern**.

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

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

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

Dr Stephen Dunn
Chief executive
23 June 2020

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2019 to 31 March 2020

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of West Suffolk NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in West Suffolk NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

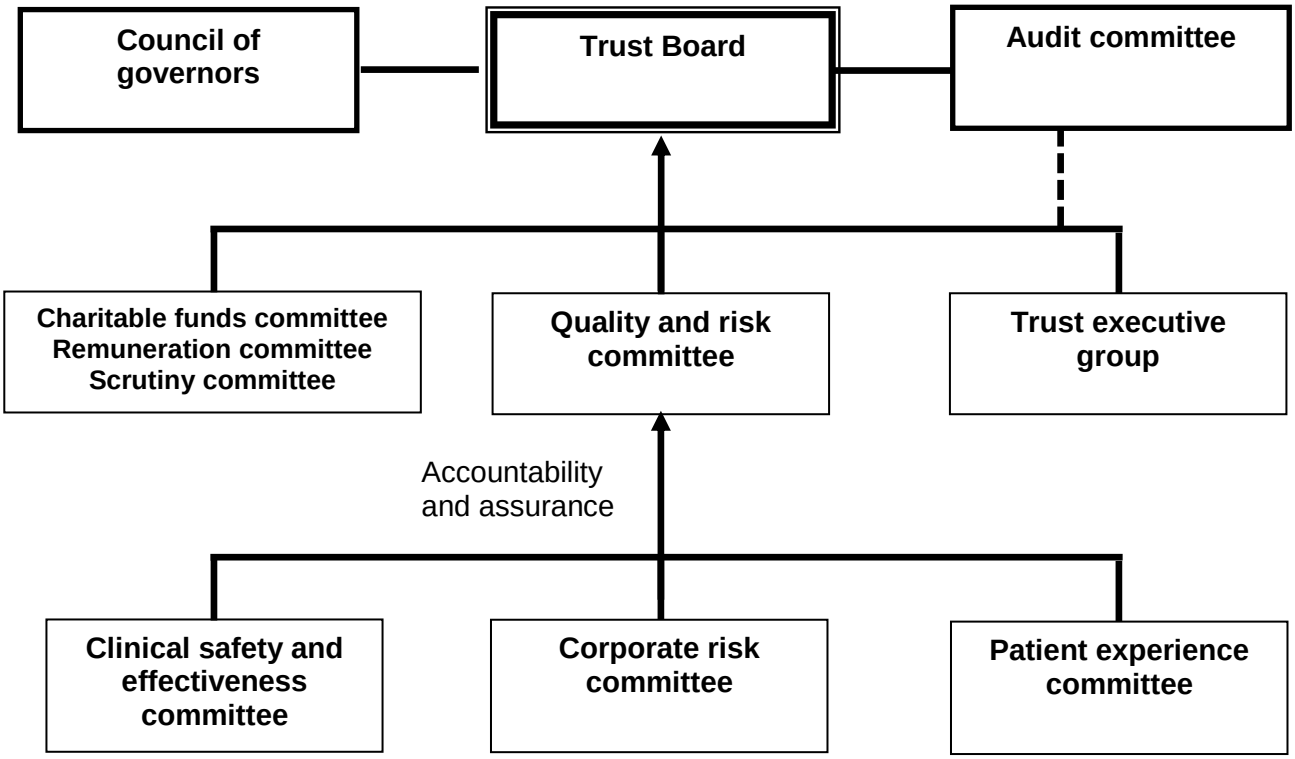
The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to foundation trusts. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust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

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

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

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

Chart 1: Governance structure



The council of governors holds the non-executive directors to account for the performance of the Board.

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

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

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

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

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

The risk and control framework

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

Risk is assessed at all levels in the organisation from the Board of directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed. Risk assessment information is held in an organisation-wide risk register. The level of risk that the Trust is willing to take (risk appetite) is managed through this structured framework of risk assessment and

appropriate escalation. The Board retains oversight of significant (red) operational, corporate and strategic risks. The Board reviewed its risk appetite during 2018/19 and this will be further developed during 2020/21.

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

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

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

- **Care Quality Commission (CQC)** – an overall rating of "requires improvement"
- **Performance against national targets**, meeting a number of national targets in 2019/20
- **Awarded status of global digital exemplar**
- **Excellent reputation for teaching** – both undergraduate and graduate.

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

- In a national survey, the CQC reported that our emergency department is performing better than most in the country in several areas of urgent and emergency care
- We were named one of 40 CHKS Top Hospitals for 2019 in the leading data-driven awards that have been running for 18 years
- The Royal College of Physicians' national lung cancer audit reported that WSFT demonstrated a 40.1% one-year survival rate for this serious disease, a higher average rate than the regional and national rates of 34.6% and 37% respectively

- Our role was also acknowledged by our commissioners the West Suffolk Clinical Commissioning Group, in its achievement of the best cancer survival rates in the east of England
- The Macmillan Unit, which cares for people with cancer, has scored highly in its MQEM (Macmillan Quality Environment Mark) accreditation reassessment, maintaining an overall score of 4 (very good) and retaining its high standards
- Our state-of-the art acute assessment unit (AAU) is now fully completed and was officially opened in October
- A change in legislation allowed the ownership of Newmarket Community Hospital to be transferred to the WSFT from NHS Property Services this year
- We were pleased that the percentage of people responding to the annual NHS staff survey increased by four per cent to 52%, which is also above the national average of 48%. There were many positive indicators for us, with a staff engagement score equal to the best in the country; and the morale and safety culture scores close to the highest national scores. Eight of the 11 themes in the survey had an improved score, three of those showing significant improvement, three were unchanged, and our community staff expressed the highest level of satisfaction across the Trust, a tribute to their leaders
- Our staff gave us a vote of confidence In the NHS Staff Friends and Family Test, with 92% of staff surveyed saying they would recommend the WSFT as a place to receive treatment, the seventh highest percentage in England. In addition, 79% said they would recommend it as a place to work, which is the tenth highest percentage in the country
- As part of our commitment to staff welfare, we opened three new accommodation blocks at the Bury St Edmunds site
- This year we made significant strides in managing the many nursing vacancies we had across the hospital, which was putting added pressure on staff to maintain quality, safe patient care. Our vacancy rate was also addressed by the launch of our imaginative, responsive #BeKnown recruitment campaign, which is a long-term project to attract people to apply to us in any professional capacity and ensure the work of the Trust is fully supported
- Our training and education team has been recognised in two national award schemes this year. Once again we achieved the highest score in the East of England for doctors' overall training satisfaction in acute trusts. The doctors at our Trust surveyed in the General Medical Council's (GMC) national training survey 2019 rated their overall satisfaction at 82%, a three per cent increase on last year
- And a longstanding partnership between WSFT and West Suffolk College has seen us shortlisted for health and science apprenticeship provider of the year category in the FE Week and AELP AAC Apprenticeship Awards 2020.

But, we also have some challenges and these are considered in more detail in the conclusion of this annual governance statement:

- **CQC inspection findings – staff engagement and raising concerns**
- **West Suffolk Hospital building structure**
- **Pathology services**
- **18-week maximum wait and cancer standards**

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

Board assurance framework summary

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Quality of care	Quality or service failure, leading to reputation damage, reduced activity/income and/or regulatory action	Poor care and treatment of patients. Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Restricted authorisation / licensing by regulators

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

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Governance	External financial constraints impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or NHSE/I). Impact on cash flow and income and expenditure. Inability to generate sufficient surplus to support capital investment. Local position leads to tension between local health economy partners. Loss of provider sustainability funding to the local health system
	Development and delivery of the West Suffolk Alliance way of working as the local delivery unit for the integrated care system (ICS)	Ability to deliver safe and sustainable services for local population. Local position leads to tension between local health economy partners. Loss of provider sustainability funding to the local health system. Loss of confidence in WSFT and west Suffolk system

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

- integrated quality and performance report (IQPR) and finance and workforce report - both reports are received at each public Board meeting. These reports detail a range of metrics including patient outcomes, patient experience and staffing performance indicators
- nurse staffing monthly report to the Board which details the nurse staffing position and the Trust's future plans for nurse staffing
- Board reporting is underpinned by monthly divisional workforce reports which details a range of performance indicators including sickness absence, turnover, maternity leave, training and average absence
- assessment of staff experience using the friends and family test (FFT), national staff survey and exit interviews. We have also established networks for staff with disabilities and LGBT+
- Freedom to Speak Up Guardian and Guardian of Safe Working reporting to the Board
- e-rostering and e-job planning system for medical staff
- the Trust's clinical workforce strategy group oversees the development of new roles to support sustainability within the labour market.

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

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). An improvement plan is in place to address the concerns identified in the recent CQC inspection.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

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

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

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

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

The board assurance framework provides evidence of the effectiveness of controls that manage the risks to the organisation achieving its principal objectives and that these have been reviewed. The annual governance statement is also informed by the latest CQC inspection report (January 2020).

The board assurance framework was reviewed and updated routinely during 2019/20 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for impact and likelihood. Overall, analysis of key controls and assurances revealed that the Trust was managing its risks to a reasonable level, that the Board of directors was adequately informed of the effectiveness of control measures and that, where possible, appropriate corrective action was being taken to reduce identified high-level risks. This review has identified gaps in control or assurance as set out in the significant internal control section of the annual governance statement. The board assurance framework was subject to independent review by internal audit during 2018/19.

In considering the principal risks to compliance with the Trust's conditions of authorisation we have had particular regard to the:

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

Information governance

The Trust's information governance assessment report overall score for 2019-20 was 44/44 assertions met. All 118 mandatory evidence items were provided. The Trust reported four data breaches to the Information Commissioner's Office (ICO) in 2019/20. These incidents involved:

- Lost or stolen paperwork (1)
- Unauthorised access or disclosure (3)

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

Data quality and governance

The Trust places a high priority on the quality of its clinical outcomes, patient safety and patient experience and strives to deliver the principles outlined in NHSI's well-led framework and its eight key lines of enquiry (KLOEs):

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

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

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

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

The Board has developed the use of statistical process control (SPC) charts to allow quality and performance indicators to be more systematically reviewed and to target action to the areas that require attention. The SPC method allows areas affected by change to be more easily identified and

investigated, whether this change is positive or negative. The use of SPC intelligence will be developed to be used more widely across the Trust.

Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

Review of effectiveness

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

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

The Board of directors has put in place a robust escalation framework which ensures timely and effective escalation from divisions and specialist committees to the Board. Executive directors and their managers are responsible for maintaining effective systems of control on a day-to-day basis.

In accordance with the public sector internal audit standards in 2013, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the Board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Internal audit reported five reports from the 2019/20 plan; the "opinion levels" are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	1
Substantial assurance - controls are suitably designed, consistently applied and operating effectively.	1
Reasonable assurance - identified issues that need to be addressed	1
Partial assurance - action is needed	1
No assurance - urgent action is needed	1

The conclusions from the one 'partial' and 'no' assurance reports are set out below and action to address the concerns have been reviewed by the audit committee:

- **Procurement** (partial assurance) – areas of weakness related to a lack of process regarding contract monitoring and the retention of contract documentation, with no standardised process for the monitoring of contracts defined across the Trust. The audit also noted a lack of tender waiver analysis including departments with a high number of waivers or those applying for high value waivers.

- **Freedom to speak up** (no assurance) - areas of weakness related to the design of controls and the adherence to existing controls in place. The audit noted that whilst the Trust has various

reporting channels for concerns to be raised, there is a significant discrepancy in how those concerns are documented, investigated and reported including the notification of the number and themes of concerns raised via alternative channels to the Freedom to Speak Up (FtSU) Guardian for both internal reporting to the Trust Board and external reporting to the National Guardian's Office. The audit also noted that records lack the expected requirements in line with the National Guardian's Office and that demonstrating compliance in the event of an inspection by the National Guardian's Office or the CQC would be difficult, due to the inconsistencies noted in the recording mechanisms. There is also an absence of a lessons learned process to capture and learn from concerns raised and that submissions to the National Guardian's Office do not reconcile to records retained and are at risk of having been understated.

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

For the 12 months ending 31 March 2020, the head of internal audit's opinion for WSFT is that: "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

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

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

Conclusion

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

- **CQC findings – staff engagement and raising concerns**

  A full inspection by the Care Quality Commission (CQC) resulted in our being given a rating of "requires improvement". As we had previously been rated "outstanding" this was a great disappointment. The CQC sought action on things the Trust must do and where improvement is needed. It is important to note that the CQC rated many of our services as good or outstanding and found that across the board patients were treated with compassion and respect.

  A significant concern for the Trust was that staff do not always feel able to raise concerns. All our employees were invited to respond to this year's NHS staff survey, which brought encouraging findings, as did the NHS staff friends and family test, with positive comparisons regionally and nationally. At the same time it is clear we need to listen more to our colleagues, be informed by their views, offer specific support to teams and have a greater focus on leadership and continuous learning.

  We are reviewing our culture and openness to make sure everyone – including our patients, our staff and our commissioners – can contribute to our improvement. We are supporting staff conversations, enhancing the support offered through our HR policies and focusing more intently on staff wellbeing. We have developed a robust improvement plan, and progress on this will be monitored by our Board and reported to the CQC. We welcome and will fully co-operate with the independent review commissioned by the Department of Health and Social Care into whistleblowing concerns.

- **Building structure**

  The building structural challenges we face at West Suffolk Hospital are well known and we have long documented that, according to structural engineer experts, our building's 'shelf life' likely won't extend beyond 2030. It's been nationally acknowledged that we need a new hospital.

  The Trust has faced estate challenges regarding its roof for a number of years, and has put approved mitigations in place, like reducing weight on the roof. These risks have been well-managed and well-mitigated. Recently an additional, specific structural risk was identified about a product called a reinforced autoclaved aerated concrete (RAAC) plank, which was used in the original build of West Suffolk Hospital and the front residences in the 1970s.

  The alert received was from the Standing Committee on Structural Safety (SCOSS), which reported one sheer RAAC plank failure in a non-NHS site. Of the 400,000 planks manufactured, there have been two reported failures of this kind. Our estates development team have been proactive, robust and absolutely on the front foot in tackling this issue, and we're very proud of their response. Since receiving the alert, they have mapped every plank across the organisation, and are robustly assessing each plank individually to look for any signs of stress as identified in the safety alert. These assessments will continue on a rolling programme.

  They're utilising the best quality, most sophisticated equipment available to them to do this, including radar equipment and other approved tests. The Trust has also engaged experienced structural engineers and experts to support the inspection work.

  We are not complacent - this has and will continue to have our absolute attention and focus. Staff, patient and visitor safety matters to us above all else, and we would not keep an area of the hospital open if we found something that caused us particular concern and it could not be mitigated through other means, e.g. introducing failsafe supports.

  This issue has not been caused by a failing of the Trust, which has managed its estates repairs well within the means available, but by the aging of a product in our roof that cannot be replaced. We have been consistently reporting our concerns and our findings to our regulators. We want to be transparent about our challenges and to reassure our community. So, as well as informing staff, we invited media colleagues into the Trust to discuss this issue and our mitigations.

  The programme of work to inspect the building structure and implement required mitigating action continues and we have received additional funding to support the programme during 2020/21.

- **Pathology**

  The quality of pathology service delivered to the WSFT by North East Essex and Suffolk Pathology Services (NEESPS) has continued to be a cause for concern during 2019/20.

  The Medicine Healthcare Regulatory Authority (MHRA) undertook planned inspections of the blood transfusion service operated by NEESPS within the WSH during the year which highlighted some deficiencies with the service. While the MHRA recognised that improvements have been made, they emphasised that further work is required.

  In April 2020 East Suffolk and North Essex NHS Foundation Trust (ESNEFT) announced that the current NEESPS networking arrangement with the Trust will cease no later than 31st October 2020. While this means that we will once again need to reconfigure pathology services for the Trust and our local population, it provides us with an opportunity to put in place a clinically-led solution to the provision of sustainably networked pathology services to meet our current and future needs. We continue to work in partnership with ESNEFT to manage this transition safely.

- **Access, including referral to treatment (RTT) and cancer**

  During 2019/20 we continued to work through plans to recover sustainable cancer performance. Prior to the response to the COVID-19 emergency we were on track to deliver in accordance with the integrated care system (ICS) cancer alliance plans. To achieve this we have worked with NHSI's intensive support team (IST) to review our systems and processes for the management of cancer pathways and working the clinical teams had delivered pathway changes across the first phase of tumour sites (colorectal, lung and prostate). In the early stages of the COVID pandemic in response to advice and guidance from the Royal Colleges all non-emergency endoscopy activity ceased and capacity in radiology was significantly reduced. While we continued to run services to treat patients diagnosed with cancer we have built up a significant backlog of patients on cancer pathways awaiting diagnostics to determine their care pathway.

  All of these patients were clinically reviewed, triaged and have been carefully monitored. We are now opening up services to address the backlog based on clinical prioritisation. The order in which we treat patients will also be determined by the clinical prioritisation, rather than waiting time until we have addressed the backlog and returned to a normal service delivery model.

  The context of our waiting list position is a significant reduction in referrals from primary care as well as cessation of normal surveillance programmes such as breast screening. Therefore, as these activities return to normal levels we expect to see an increase in patients presenting late in their pathway adding further pressure to an already stretched service.

  In terms of RTT we completed detailed capacity and demand analysis at a specialty level using the national IST model. We had clearly articulated our capacity gaps and in conjunction with the CCG were developing detailed plans to recover performance to agreed level. But these plans recognised that we would be unable to achieve the national 92% access standard within 2019/20.

  In order to prepare to treat the anticipated demand for COVID-19 all non-urgent and non-cancer activity which required patients to attend the hospital was cancelled. We rapidly enabled clinicians to undertake telephone and video consultation with patients where clinically appropriate. All patients who were cancelled by the Trust or cancelled themselves as a result of the COVID pandemic were appropriately coded and held on waiting lists with open pathways (the time to access their required treatment still being counted).

  The number of routine referrals has significantly reduced as a result of the pandemic and those referrals that were received have been accepted and held by the Trust. As a result of the changes, fewer referrals and long-standing referrals, the profile of the waiting list has changed significantly with an increase in patients experiencing long waits (over 18-weeks and over 52-weeks) but an overall reduction in the size of the waiting list. This exacerbates the deterioration in reported performance.

  As activities return to normal we anticipate seeing a surge in unmet demand.

  The requirements of social distancing, enhanced infection control and personal protective equipment (PPE) will have a negative impact on the capacity of all services. This will lead to a reduction in the number of cases treated within our existing capacity. In response to this we are working through our COVID recovery plans with the CCG and the regional team to consider the following options to mitigate this risk:

  - Continuing use of the independent sector
  - Use of our stand-alone day surgery unit as an elective inpatient facility
  - Capital bids for additional theatre and inpatient ward capacity
  - Consideration of the workforce implications for extended hours.

- **Covid-19 – operational response and impact**

Although not considered to be a significant internal control issue for the Trust the national emergency response to COVID-19 has materially impacted on the Trust's operations in March 2020 and beyond. We established a number of command and control structures outside of our usual operational arrangements, to enable us to respond to the national emergency status of the pandemic.

As a Trust, we have a "command, control and coordination plan", also known as a "C3" plan. It covers the arrangements we use when responding to an incident that might affect our business as usual, or stop us from delivering services in the way we would normally. Responding to COVID-19 falls into that category, so we have followed the C3 plan with enhanced capability and resources to support our response. These included:

- **Strategic commander**: the strategic commander has overarching responsibility for the Trust's response to COVID-19. Our strategic commander is the chief operating officer (COO). Supported by members of the executive team, the COO leads a strategic group that considers and approves recommendations from the core resilience team (CRT), and tactical group.

- **Tactical**: looks after the day-to-day issues, that is things that need action immediately. It also decides how to put strategic group decisions into practice, and implements them. It's sub-groups include:

    - Operational: how we put decisions into practice in a way that works
    - Resources: managing things like PPE stocks
    - Divisional operational command centres (DOCCs): this is a technical name for the teams looking after specific operational areas – including surgery, community, medicine, women and children's services, and patient flow. Staff can contact them directly for operational issues related to these areas.

- **Core resilience team**: Looks after the 'mid-term' issues. It includes the following sub-groups:

    - Clinical: made up of clinical colleagues from across the Trust. It covers things like making sure we are following and implementing the right clinical guidelines
    - Community: community teams face very different challenges to acute colleagues, so this group looks at those specifically. It includes how we link with other providers, like care homes
    - Workforce: all things 'staff', including wellbeing and risk assessments, linking in with occupational health
    - Future planning: considers how we will turn services back on, in what order, and what support the Trust might need moving forward
    - Ethical: a group to temperature check some of the difficult decisions we've had to make. For example, the temporary suspension of, and then reinstating, services and activities.

The structures we put in place through our emergency planning arrangements supported us in responding to internal and external requirements and allowed the Trust to continue to provide emergency and urgent care to our patients. Significant changes to the operational arrangements were managed and delivered in a timely and considered manner. However, we do not underestimate the impact of the decisions and changes we made had on patients, relatives and our staff. It is significant to note that the head of internal audit's opinion is a position opinion despite the challenges placed on us through Covid-19, demonstrating that we were able, through our existing plans, to implement an effective control environment.

Despite the challenges that Covid-19 presented there are also opportunities for us to achieve sustainable improvements based on how we responded, such as the transformation of our outpatient services to enable virtual consultations by phone and video and the cross-agency collaboration to meet patients' needs. These and other changes were underpinned by a clinically-

led approach to developing and delivering solutions – the value of this has been clear and we must further strengthen this clinical engagement in our managerial structures and decision-making. We will use a formal review process to capture learning, positive and negative, and this will inform future developments.

I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of processes of internal control and assurance. This includes the effective tracking of action to mitigate significant control issues through the board assurance framework.

Dr Stephen Dunn
Chief executive
23 June 2020

2.7 Remuneration report

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

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

The following parts of the remuneration report are subject to audit:

- Single total figure table of remuneration for each senior manager
- Pension entitlement table and other pension disclosures for each senior manager
- Fair pay disclosures
- Staff report: exit packages, analysis of staff numbers and analysis of staff costs.

Annual statement on remuneration

There were no new appointments to executive roles during 2019/20. Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses.

Senior managers' remuneration policy

Senior managers' pay consists of the following elements:

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

To determine senior manager salaries the Remuneration Committee may use one or more of the following:

- An assessment of the Trust's performance
- An assessment of an individual's performance against agreed objectives
- NHS cost of living pay rise, based on the national NHS pay award
- Benchmarking data, including NHSI guidance and established ranges
- NHS and other relevant advertised jobs
- The prevailing market position, including the ability to recruit and retain individuals.

Remuneration Committee

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

- Advise the Board about appropriate remuneration and terms of service for the chief executive, other executive directors and other senior employees including:
  - all aspects of salary (including any performance-related elements/bonuses)
  - provisions for other benefits, including pensions and cars
  - arrangements for termination of employment and other contractual terms

- Make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff
- Scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate, advise on and oversee appropriate contractual arrangements for such staff
- Monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including:
    - establishing the objectives of the chief executive and review the performance of the chief executive against these objectives
    - scrutinising the objectives of the executive directors (to be established by the chief executive) and review performance reports on the executive directors prepared by the chief executive.
- Scrutinise the recommendations of the clinical excellence awards committee
- Review the terms of reference of the committee every two years
- Report the frequency of meetings and the members of the remuneration committee in the Trust's annual report
- The Committee shall report in writing to the Board the basis for its recommendations
- Consider the Trust's equality, diversity and inclusion policy in all decisions made, the objectives of which are linked to the Trust's overall strategy.

The committee comprises the Trust chair and non-executive directors of the Board. The committee is chaired by a non-executive director (Mr A Eaton). The chief executive, executive director of workforce and communications and trust secretary may be present to advise but not for any discussions concerning their personal remuneration at the discretion of the remuneration committee's chair.

A quorum will consist of the committee Chair (or nominated representative) and at least two non-executive directors. A nominated representative for the chair must be a non-executive director.

The committee acts with delegated authority from the Board and will usually meet at least annually. Minutes are taken and a report submitted to the Board showing the basis for the recommendations. Three meetings of the committee were held during 2019/20. All non-executive directors were in attendance for all meetings.

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

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

Service contracts obligations

The Trust's executive directors hold substantive service contracts. Notice periods apply based on the early termination of their contract. The notice periods are as follows:

- Chief executive – six months
- Executive directors – three months.

Policy on payment for loss of office

Approval for any non-contractual severance payments should be obtained from the remuneration committee and NHSI following submission of a business case. In respect of individuals earning over £100,000, any severance payment should include a provision requiring the repayment of the severance payment where the individual returns to work for the NHS in England within 12 months and/or before the expiry date of the period for which they have been compensated (as measured in equivalent months/part-months of salary). In such circumstances the employee would be required to repay any unexpired element of their compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary.

Annual report on remuneration

In the financial year the directors' costs increased to £1,197k from £1,191k. There were no exit packages paid to Board members in the 2019/20 financial year or the comparative year.

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

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

Both directors and governors are able to reclaim expenses necessarily incurred during the course of their duties. Details of these are shown below. The numbers include individuals who have acted in their capacity as director or governor for any part of the financial year.

	2019/20		2018/19	
	Directors	Governors	Directors	Governors
Total number in office during the year	13	25	13	26
Total number receiving expenses	8	8	6	7
Aggregate total of expenses paid during the year (£)	14,211	1,805	9,134	1,525

Fair pay disclosure

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

The banded remuneration of the highest paid director in the Trust in the financial year 2019/20 was £185k - £190k (2018/19, £180k - £185k). This was 7.6 times (2018/19, 8 times) the median remuneration of the workforce, which was £24,616 (2018/19, £23,951). This is calculated based on all staff employed, including agency nursing staff covering vacancies, as at 31 March 2020.

In 2019/20, seven employees (2018/19, one employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £17,652 to £218,196 (2018/19 £17,460 to £202,819).

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

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

Table A – Remuneration

Name and title	Year to 31 March 2020				Year to 31 March 2019			
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Salary paid (bands of £5,000)	Expense payments (taxable) to nearest £100	Increase in pension entitlement (bands of £2,500)	Total (bands of £5,000)
	£000	£	£000	£000	£000	£	£000	£000
Mrs H Beck - chief operating officer	120 - 125	1	80 - 82.5	205-210	110 - 115	1,700	112.5 - 115	225 - 230
Mr C Black – executive director of resources	140 - 145	96	42.5 - 45	195 - 200	135 - 140	7,100	52.5 - 55	195 - 200
Ms J Bloomfield – executive director workforce and communications (Note 1)	25 - 30	-	-	25 - 30	105 - 110	200	120 - 122.5	230 - 235
Mrs S Childerhouse - chair	45 - 50	1	-	45 - 50	45 - 50	-	-	45 - 50
Dr R Davies - non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr S Dunn – chief executive	180 - 185	109	32.5 - 35	225 - 230	175 - 180	9,400	82.5 - 85	270 - 275
Mr A Eaton - non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr N Jenkins - medical director (Note 2)	185 - 190	2	72.5 - 75	255 - 260	175-180	-	47.5 - 50	225 - 230
Mr G Norgate – non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Mr J Over – executive director workforce and communications (Note 3)	45 - 50	-	10 - 12.5	60 - 65				
Mrs L Pepper - non-executive director (Note 4)	10 - 15	1	-	10 - 15	5 - 10	-	-	5 - 10
Ms R Procter – executive chief nurse	115 - 120	83	10 - 12.5	135 - 140	120 - 125	-	52.5 - 55	170 - 175
Mr A Rose - non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Mr S Turpie – non-executive director (Note 5)					0 - 5	-	-	0 - 5

No additional performance pay and bonuses were paid in 2019/20 or 2018/19.

Notes

1. J Bloomfield retired in April 2019 and came back on a fixed term contract until October 2019

2. N Jenkins remuneration includes payments for clinical sessions.

3. J Over was appointed as the executive director workforce and communications in November 2019

4. L Pepper started as a non-executive director in September 2018

5. S Turpie left May 2018

Table B – Pension benefits to 31 March 2020

Name	Real increase / (decrease) in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash equivalent transfer value at 1 April 2020	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2019
	£000	£000	£000	£000	£000	£000	£000
Mrs H Beck (Note 6)	2.5 - 5	12.5 - 15	45 - 50	135 -140	0	0	0
Mr C Black	2.5 - 5	0 - 2.5	45 - 50	100 - 105	824	55	751
Dr S Dunn (Note 7)	2.5 - 5	0 - 2.5	70 - 75	0	943	53	869
Dr N Jenkins	2.5 - 5	2.5 - 5	40 - 45	80 - 85	636	72	551
Mr J Over	0 - 2.5	0 - 2.5	30 - 35	60 - 65	444	16	417
Ms R Procter	0 - 2.5	0 - 2.5	30 - 35	60 - 65	503	22	470

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

The NHS Pensions Agency is considering the impact on the McCloud v Sargeant pension ruling. The benefits and related cash equivalent transfer values noted in the table above do not allow for any future impact from this ruling. During 2019/20, the Government announced that all public sector pension schemes will be required to provide indexation on the guaranteed minimum pension element of an individual employee's pension. The NHS Pensions Agency updated the methodology used to calculate the cash equivalent transfer values as at 31 March 2020 and the impact of that change is included in the cash equivalent transfer values as at 31 March 2020, included in the table above.

Notes

6. H Beck is over normal retirement age therefore a CETV calculation is not applicable

7. Lump Sum is zero as a member of 2008 Section and 2015 Section which does not provide an automatic lump sum

Dr Stephen Dunn
Chief executive
23 June 2020

2.8 Staff report

2.8.1 Our staff

The Trust is one of the largest employers in west Suffolk, employing 4,353 staff in April 2020. It firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2019/20 with the following activities:

- The Trust was one of those to achieve the best rating in the country for the staff engagement theme in the 2019 national NHS staff survey
- The percentage of staff recommending WSFT as a place to work in the 2019 national NHS staff survey was well above average for comparable trusts
- A Freedom to Speak Up Guardian for the Trust, and Guardian of Safe Working for junior doctors, continue to support an open and inclusive culture
- Staff governors also continue to support staff to discuss challenges and achievements and report back on these
- As part of the Trust's health and wellbeing programme we continue to focus on both emotional and physical health and wellbeing, by offering mental health awareness sessions for managers, Care First (a telephone helpline for all health and wellbeing issues) and practical support to help maintain healthy lifestyles
- Staff continue to receive financial assistance in the form of low-interest loans which are arranged by an external organisation, and have access to an occupational health service at WSH, including a physiotherapist and counselling
- Staff have the opportunity to join local gyms at a discounted rate
- An active flu campaign improved the uptake of the flu vaccine among staff to 80.03% in 2019/20 which was the highest level ever achieved
- We have continued to support the trade union convenor role
- We continue to develop our partnership working through the following committees:
  - Trust council
  - Trust negotiating committee (general staff)
  - Trust negotiating committee (medical and dental)
  - Health and wellbeing steering group
  - Equality, diversity and inclusion steering committee.

2.8.2 Staff costs

	Permanent £000	Other £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	142,908	131	**143,039**	131,472
Social security costs	14,160	-	**14,160**	12,984
Apprenticeship levy	696	-	**696**	635
Employer's contributions to NHS pensions [1]	25,137	-	**25,137**	15,595
Pension cost - other	51	-	**51**	31
Temporary staff	-	5,792	**5,792**	5,188
Total staff costs	**182,952**	**5,923**	**188,875**	**165,905**
Of which				
Costs capitalised as part of assets	4,239	41	**4,280**	3,236

[1] The increase for 2019/20 reflects the change in the employee contribution within the NHS pension scheme.

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

	Permanent number	Other number	2019/20 Total number	2018/19 Total number
Medical and dental	448	46	**494**	461
Administration and estates	718	41	**759**	757
Healthcare assistants and other support staff	776	107	**883**	790
Nursing, midwifery and health visiting staff	1,047	82	**1,129**	1,065
Scientific, therapeutic and technical staff	576	7	**583**	538
Total average numbers	**3,565**	**283**	**3,848**	**3,611**
Of which:				
Number of employees (WTE) engaged on capital projects	73	-	**73**	56

2.8.4 Reporting of compensation schemes - exit packages 2019/20

There was one compensation scheme - exit package in 2019/20 with a total resource cost of £30,900. There were no compensation schemes - exit packages in 2018/19. There were no non-compulsory departure payments in 2019/20 or 2018/19.

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

	Male	Female	Total
Executive directors (including CEO)	4	2	6
Non-executive directors (including chair)	4	2	6
Other senior managers (band 8d and above)	7	5	12
Employees	794	3,535	4,353

2.8.6 Sickness absence data

The Trust has systems and processes in place to manage both long- and short-term sickness absence, in accordance with best practice and legislative requirements. The performance for the year is available via https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

2.8.7 Trade Union facility time information

Number of employees who were trade union officials	Whole time equivalent
29	25.5
Percentage of time spent on facility time	**Number of employees**
0%	27
1%-50%	7
51% - 99%	1
100%	0
Total cost of facility time	**Costs**
Total pay bill	£182,987,000
Percentage of pay bill spent on facility time	0.018%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
1,291.5	2.6%

2.8.8 Equality and diversity

The Trust is committed to the provision of high quality, safe care for all members of the communities it serves and to the development of a culture of inclusion where all people are valued and respected for their individual differences; as evidenced by our strategic framework: *Our patients, our hospital, our future, together*.

This means we will embrace all people irrespective of, for example, race, religion or belief, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability. We will give equal access and opportunities and remove discrimination and intolerance. We will do this both as an employer and as a service provider.

Our **inclusion strategy objectives** are:

For **patients, service users and carers**:

- Improve the experience and care of patients and service users experiencing mental distress those with learning disabilities and neurodiversity
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities.

For **staff:**

- Promote and support inclusive leadership at all levels of the Trust
- Ensure recruitment and selection processes are bias-free and inclusive
- Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the Trust on issues of equality, diversity and inclusion
- Take action to support the mental health and wellbeing of all staff.

For **patients, service users, carers and staff**:

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.

Our objectives have been drawn from an in-depth analysis of progress to date with our equality delivery system (EDS), a review of EDS2 goals and outcomes, a review of our performance against the nine NHS Workforce Race Equality Standard indicators, national staff survey results, our gender pay gap report, the Trust's strategic framework '*Our patients, our hospital, our future, together'* and the requirements of the Equality Act (2010), including the Public Sector Equality Duty (PSED).

Our objectives were reviewed and updated in the summer of 2019 for August 2019 to July 2021. Progress is monitored quarterly by the equality and diversity steering group and an annual report is received by the Board.

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

Employees and public members protected characteristics

	Staff in post				Public Members			
	2019/20	2018/19	2017/18	2016/17	2019/20	2018/19	2017/18	2016/17
Age								
16	0	0	0	0	0	0	0	1
17-21	54	64	49	61	71	51	65	34
22+	4,299	3,981	3765	3597	6,105	5,800	5,854	5,963
Not specified	0	0	0	0	120	123	126	170
Total	4,353	4,045	3814	3658	6,296	5,974	6,045	6,168
Ethnicity								
White	3,500	3,382	3182	3078	5,600	5,331	5,391	5,565
Mixed	49	44	40	37	34	29	28	28
Asian or Asian British	461	312	264	263	95	88	90	72
Black or Black British	29	31	27	22	28	23	23	23
Other ethnic group	39	42	39	36	35	30	30	69
Not stated	198	213	257	66	504	473	483	411
Undefined	77	21	5	156	0	0	0	0
Total	4,353	4,045	3814	3658	6,296	5,974	6,045	6,168
Gender								
Female	3,544	3,281	3111	2966	3,932	3,673	3,684	3,716
Male	809	764	703	692	2,364	2301	2361	2452
Total	4,353	4,045	3814	3658	6,926	5,974	6,045	6,168
Disability								
No	2,104	1,770	1557	1387	-	-	-	-
Not declared	365	327	356	286	-	-	-	-
Undefined	1,227	1,276	1798	1897	5,661	5,338	5,386	5,434
Prefer not to answer	516	558	-	-	-	-	-	-
Yes	141	114	103	88	635	636	659	734
Total	4,353	4,045	3814	3658	6,296	5,974	6,045	6,168

Source: Electronic Staff Record (as at 1/4/2020)

Disability and equal opportunities policies

The Trust is committed to a policy of equal opportunities in employment and service delivery. Everyone who comes to the Trust, either as a patient or visitor, or who works in the Trust, or applies to work in the Trust, should be treated fairly and valued equally. Our Trust policies and strategies (the equality delivery system, recruitment and retention of people with disabilities, supporting people who are trans policy and equal opportunities policy) all support this focus.

The Trust completes an annual action plan based on its performance against the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap reporting, the national NHS staff survey and other locally identified priorities.

Gender pay gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31 March each year. You can download our gender pay gap report for 2019 here.

2.8.9 Health and safety report

The Trust's health and safety performance is reported to and monitored by the health and safety committee which then escalates any issues of concern to the corporate risk committee. Both of these committees meet quarterly. Issues that cannot be resolved or which need to be escalated are reported to the trust executive group and the Board of directors.

Risk assessment

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

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

Between April 2019 and March 2020, 41 members of staff were trained in the principles of health, safety and risk assessment. This has improved the quality and quantity of risk assessments and has helped to promote the use of the risk register.

Workplace inspections are undertaken by health and safety link persons who are qualified with the Royal Society for Public Health (RSPH) Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. 233 members of staff have now gained this qualification. Once completed, the inspection is captured on the risk register so actions can be monitored.

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR)

Between April 2019 and March 2020 20 incidents were reported to the Health and Safety Executive (HSE) as required under RIDDOR (25 in 2018/19).

There were no RIDDOR reportable incidents from a needlestick incident or asbestos-related incidents. There was a slight decrease in the category of moving and handling (from nine to six incidents); and violence and aggression from five to two. There was an increase in the category of struck by moving/falling object (from zero to one incident).

RIDDOR description	2019/20	2018/19
Moving and handling incidents	6	9
Slips, trips and falls	6	6
Health and safety incidents	5	5
Violence and aggression	2	5
Struck by moving/falling object	1	0

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

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

Of the 20 incidents reported to the HSE, 15 incidents were due to being off work for more than seven days following an incident. The health and safety committee reviews incident trends, including RIDDORs to ensure that appropriate learning takes place and action is taken.

Incident reporting system

The Datix incident reporting system is used to capture all clinical and non-clinical incidents. Non-clinical incidents include reports of personal accidents, violence and aggression, abuse and harassment, fire, and security breaches. All incidents, no matter the grade, are investigated and reported according to the Trust's incident policy and procedure. Actions taken as a result of

investigations are communicated through the divisional governance groups. The Board of directors receives a quarterly report summarising incident trends and action.

Between April 2019 and March 2020 there were 302 violence, abuse and harassment incidents - an increase of 73 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Of the 302 incidents reported there were 137 physical assaults, and 100 were recorded as having a clinical cause. Clinical-caused incidents are those whereby the patient is not aware or has no control of their actions. This can be postoperative due to having a general anaesthetic or, more commonly, the patient is suffering from dementia or is cognitively impaired. The Trust has introduced training to support staff in managing challenging behaviour.

There were 1,765 reported incidents of personal accident or ill-health during 2019/20. This is an increase of 197 incidents (11%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories, which include slips/trips/falls, contact with an object, contact with a sharp object such as a needle, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'.

2.8.10 Occupational health report / occupational health and wellbeing service

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

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as being a marker of a good employer.

We continue to work with our partner Oh: Occupational Health and Wellbeing to deliver our agreed priorities for health and wellbeing and the programme is led and overseen by the Trust health and wellbeing steering group. Our West Suffolk Wellbeing Plan 2019-21 sets out the range of support already available to all staff and the action being taken to build on and consolidate this.

Our focus is on supporting the emotional and physical wellbeing of our staff and the support we provide ranges from help to stop smoking and weight management to training available to all staff in mental health awareness and emotional first aid.

We have seen very positive use of the Trust's employee assistant programme (EAP) provided by our partner Care First. The EAP delivers 24/7 telephone advice and counselling service, face to face counselling, support following a major traumatic event and an information service on legal, financial and social matters.

Our seasonal flu campaign continues to result in increased numbers of staff receiving the flu vaccination. In 2019/20 we achieved the national target for frontline staff with 80.03% of these staff being vaccinated.

2.8.11 Staff survey

The following report includes commentary of the national staff survey (2019). It contains details on staff engagement and survey response rates, best and worst ranking scores, the key 10 indicators and future priorities.

Staff engagement
The WSFT moved from a partial survey to a full census for the 2019 survey. This was done so the Trust could better understand the thoughts of the staff on what was working well and how we can better improve our services for the benefit of patients and the public. The Trust encourages open and

honest communication throughout the organisation. A number of methods have been developed to encourage all staff to feel that they can contribute:

- Core brief – monthly briefing cascade
- Monthly team briefings
- Freedom to Speak Up Guardian
- Guardian of safe working for junior doctors
- Senior independent director – non-executive director lead for whistleblowing
- Weekly executive director open door session in Time Out restaurant
- Executive and environmental walkabouts
- Weekly electronic staff briefing
- Monthly medical director's bulletin for medical staff
- The Green Sheet weekly staff newsletter
- The 5 o'clock club our leadership and quality improvement forum
- Staff awards – annual Shining Lights awards, monthly Putting you First awards, new Trust thank you cards, and 'The David Dumbleton Porter of the Year award' recognising the WSFT porter of the year
- Staff health and wellbeing focus groups
- Staff networks – LGB&T+ and staff disability network
- Staff engagement on corporate social media, e.g. Twitter and Facebook
- A telephone hotline and web-based reporting for raising concerns anonymously
- Trusted partners – volunteer members of staff who provide informal independent advice and a listening ear to colleagues with concerns.

Summary of staff survey

The NHS staff survey is conducted annually. From 2019 onwards, the results from questions are grouped to give scores in 11 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

There have been significant improvements in the themes of immediate managers, morale and quality of appraisals. There have been no significant changes, negative or otherwise in any of the other themes.

	2019/20		2018/19		2017/18	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.3	9.0	9.3	9.1	9.2	9.1
Health and wellbeing	6.4	5.9	6.4	5.9	6.5	6.0
Immediate managers	7.2	6.8	7.0	6.7	6.8	6.7
Morale	6.6	6.1	6.4	6.1	No data as new indicator	
Quality of appraisals	5.9	5.6	5.5	5.4	5.2	5.3
Quality of care	7.7	7.4	7.6	7.5	7.7	7.4
Safe environment – bullying and harassment	8.2	7.9	8.1	7.9	8.2	8.0
Safe environment – violence	9.4	9.4	9.4	9.4	9.3	9.4
Safety culture	7.1	7.0	7.0	6.6	7.0	6.6
Staff engagement	7.5	7.0	7.4	7.0	7.4	7.0
Team working	6.9	6.6	6.8	6.5	6.8	6.5

Summary of staff survey response

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

	2019/20	2018/19	2017/18	2016/17
Response rate	51.8%	48.4%	47.9%	50.1%
Benchmarking group	47.5%	44.4%	44.2%	42.8%

Best and worse scores against benchmarking

Best scores

Indicator	2019/20		2018/19		2017/18	
	Trust	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
Q11a. Does your organisation take positive action on health and well-being?	**38.5%**	**28.2%**	39.1%	27.7%	42.1%	31.2%
Q21c. I would recommend my organisation as a place to work	**76.5%**	**62.5%**	74.1%	62.3%	74.6%	60.7%
Q21d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	**86.2%**	**70.5%**	82.8%	71.2%	85.3%	7.6%
Q23b. I will probably look for a job at a new organisation in the next 12 months	**16.3%**	**19.9%**	17.1%	21.0%		
Q23c. As soon as I can find another job, I will leave this organisation	**10.9%**	**14.3%**	12.0%	15.3%		

Worst scores

Although question Q13d appears under the worst scores, it is also counted as one of the Trust's most improved scores, with an increase of 7.5% on the previous year.

Indicator	2019/20		2018/19		2017/18	
	Trust	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
Q12a. In the last 12 months, how many times have you personally experienced physical violence at work from patient/service users, their relatives or other members of the public?	**15.2%**	**15.1%**	15.2%	14.5%	18.5%	15.2%
Q13d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	**45.3%**	**46.0%**	37.8%	44.1%	51.1%	45.0%
Q19e. The values of my organisation were discussed as part of the appraisal process.	**33.8%**	**37.8%**	32.5%	34.8%	20.0%	32.2%

Future priorities and targets

Key priorities: the priorities will focus on our worst scoring questions, and areas that the Trust would like to see further development.

Actions:

- Discussions will be facilitated with each division with the expectation that the division contributes ideas for each of the above priorities for improvement. The improvements will be monitored at divisional performance meetings
- Create an action plan to develop improvements around the key priorities and track progress of the implementation of the improvements.

2.8.12 Pension liabilities for ill-health retirement

There was one ill-health retirement during the year to 31 March 2020 (2019: one); the additional pension liability borne by NHS Pensions was estimated as £35k (2019: £14k).

2.8.13 Policies and procedures for fraud and corruption

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

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

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

To achieve this WSFT will:

- ensure that employees, contractors, suppliers and users of our services understand that fraud is unacceptable and that they are able to raise serious concerns easily
- share information with other trusts and organisations to deal with fraud and corruption locally and nationally, working within the law
- increase awareness of fraud and corruption through a programme of training and communication
- investigate all allegations of fraud and corruption in a professional manner
- apply appropriate sanctions such as disciplinary action, criminal proceedings and recovery of losses when necessary. Where appropriate, WSFT will publicise cases demonstrating the Trust's commitment to fighting fraud.

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

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

2.8.14 Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of March 2020	7
Of which:	
No. that have existed for less than one year at the time of reporting	0
No. that have existed for between one and two years at time of reporting	2
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	1
No. that have existed for four or more years at time of reporting	4

For all new off-payroll engagements or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	0
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via personal services company contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/ assurance purposes during the year	7
No. of engagements that saw a change to IR35 status following the consistency review.	0

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

No. of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	24

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

The Trust has reviewed all off-payroll arrangements and from 6 April 2017, all arrangements have been terminated or moved on to payroll unless they are assessed as meeting HMRC's requirements to be paid gross. There were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2019 and 31 March 2020.

During 2019/20, the Trust spent £458k on consultancy costs (2018/19 £153k). Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

West Suffolk NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Contents Page

Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by West Suffolk NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Dr Stephen Dunn CBE**
Job title **Chief Executive Officer**
Date **23 June 2020**

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

Opinion on financial statements

We have audited the financial statements of West Suffolk NHS Foundation Trust (the Trust) for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and as interpreted and adapted by the 2019-20 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2019-20, and the NHS Foundation Trust Annual Reporting Manual 2019-20 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2019-20; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Emphasis of matter - material valuation uncertainty related to property assets

We draw attention to Note 12.4 to the financial statements which states that in respect of a valuation exercise carried out on the Trust's land and property the valuers have reported a 'material valuation uncertainty' on the basis of uncertainties in markets caused by Covid-19. This disclosure is consistent with a valuation practice alert issued by the Royal Institute of Chartered Surveyors (RICS). The values in the valuers' report have been used to inform the measurement of property assets in the financial statements. Our opinion is not modified in respect of this matter.

Basis for opinion on financial statements

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

Conclusions relating to going concern

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

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

Key Audit Matters

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

Matter	How we addressed the matter in the audit
Revenue Recognition Most NHS Income is subject to reconciliation and formal agreement with other NHS bodies through the Agreement of Balances (AOB) process. There is a risk, however, that other non NHS income and NHS income which is not on block contracts is not accurately reflected in the financial statements, whether as a result of fraud or error. *See Notes 1.4, 3 and 4.*	We substantively tested a sample of material NHS and non-NHS income streams to supporting documentation to confirm that income has been accurately recorded and earned in the year. This included verification of all income amounts with NHS West Suffolk Clinical Commissioning Group. We reviewed the process for resolving discrepancies between the Trust and other NHS bodies through the agreement of balances process, and management's estimate of amounts receivable where there are contract disputes, subsequently investigating all discrepancies and disputed amounts above £300,000. We agreed a sample of income with other NHS bodies back to contract amounts. We ensured that all income items tested had been accounted for in line with the Trust's revenue recognition policy. Key observations: Our testing detected no material issues regarding existence or timing of revenue recognition.
Fair valuation of Property, Property, plant and equipment is the most significant asset in the Trust's balance sheet. At this year-end the Trust has undertaken a full valuation of their land and buildings to ensure there is no material misstatement of asset values. The valuation of land and buildings is complex and is subject to a number of assumptions and judgements. A small movement in these assumptions can have a material impact on the financial statements. *See Notes 1.7, 7 and 12.*	We reviewed the instructions provided to the valuer and considered the valuer's skills and expertise in order to determine the extent to which we could rely on Management's expert. We considered whether the basis of valuation used for different classes of assets valued in year was appropriate, based on their usage. We reviewed valuation movements against indices of price movements for similar classes of assets and followed up valuation movements that appeared unusual through

Matter	How we addressed the matter in the audit
	enquiries of the Trust and directly with the valuer. We considered the reasonableness of assumptions made by the valuer in forming the valuation and determining the useful economic lives of assets valued using Trust specific sector knowledge and indices. Key observation: We considered management's judgements to be appropriate in the light of the evidence available and the increased estimation uncertainty noted by the valuer
Deposit Accrual The Trust calculates an accrual for deposits that it has to pay in respect of the hire of Community services equipment, which due to be returned post year-end. The Trust estimates the accrual using historical collection rate data and revised its methodology for calculating the accrual in 2019/20. We have considered this to be a key audit matter because this figure had a direct impact on the Trust's control total, and the calculation of the accrual is subject to a number of assumptions and judgements. *See Notes 1.18 and 13.*	We considered the basis for calculation challenging the revised assumptions used. We tested the accuracy of the historical recovery rates which were used as the basis for the calculation of the accrual. We obtained external confirmation from the equipment provider to confirm the value of amounts due to be returned as at year-end. We reviewed the assumptions and judgements used to determine the future expected recovery rates and concluded on whether they were appropriate. We reviewed the sufficiency of the disclosures made in Note 1.18. Key observations: We considered management's revised methodology and assumptions to be appropriate.

Our application of materiality

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

The materiality for the financial statements as a whole was set at £5.03 million (2019: £4.45 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.75%) (2019: 1.75%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of

£200,000 (2019: £178,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

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

Other information

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

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

We have nothing to report in this regard.

Opinion on the Remuneration Report and Staff Report

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

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

In our opinion the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2019-20.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, with the exception of the matter reported in the *Basis for qualified conclusion on use of resources* section of our report, we are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion on use of resources

For the year ended 31 March 2020 the Trust reported a deficit of £7.6 million after asset impairments of £7.9 million (2018/19: deficit of £11.6 million after asset impairments of £5.5 million).

As at 31 March 2020, the Trust had £111.1 million of borrowing, of which £58.5 million is required to be repaid in 2020/21. £46.6 million of this will be repaid through utilising additional public dividend capital due to be issued. The only viable plan to re-pay the remaining amount is to take out further borrowings due to insufficient cash balances forecast.

The planned deficit control total for 2020/21 set by NHS Improvement is £8.9 million. If achieved, this would give the Trust access to £8.9 million of additional funding, achieving a breakeven position. The Trust has agreed to work to this control total. The receipt of Covid-19 'top-up' funding is a key factor in achieving this position.

The Trust does not yet have plans to secure a return to a breakeven cash position in the foreseeable future.

This is evidence of weaknesses in proper arrangements regarding sustainable resource deployment.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit.

We also report to you if we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities the Accounting Officer

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

The Accounting Officer is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

Auditor's responsibilities for the audit of the financial statements

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

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

Auditor's other responsibilities

We are also required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

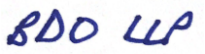
We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of West Suffolk NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Council of Governors of West Suffolk NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of West Suffolk NHS Foundation Trust those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.



Rachel Brittain
For and on behalf of **BDO LLP**, Statutory Auditor
London, UK
24 June 2020

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

Statement of Comprehensive Income for the year ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	241,576	209,723
Other operating income	4	41,597	35,229
Operating expenses	6	(102,812)	(91,746)
Employee benefits	8	(184,595)	(162,669)
Operating deficit from continuing operations		**(4,234)**	**(9,463)**
Finance income		83	64
Finance expenses		(2,443)	(1,664)
PDC dividends payable		(897)	(957)
Net finance costs		**(3,257)**	**(2,557)**
Other gains		19	111
Share of profit / (losses) of joint arrangements		(145)	359
Deficit for the year		**(7,617)**	**(11,550)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments - taken to revaluation reserve	7	(3,198)	(264)
Revaluations		-	(592)
Gain arising from on transfers by modified absorption	23	8,531	-
Total comprehensive expense for the period		**(2,284)**	**(12,406)**
Adjusted financial performance (control total basis):			
Deficit for the period		(7,617)	(11,550)
Remove net impairments not scoring to the Departmental expenditure limit	7	7,894	5,506
Remove I&E impact of capital grants and donations		105	(381)
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(280)	
Adjusted financial performance surplus / (deficit)		**102**	**(6,425)**

Statement of Financial Position as at 31 March 2020

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	11	40,972	33,970
Property, plant and equipment	12	110,593	103,223
Receivables	13	5,707	5,054
Total non-current assets		**157,272**	**142,247**
Current assets			
Inventories		2,872	2,698
Receivables	13	32,342	22,119
Cash and cash equivalents	14	2,441	4,507
Total current assets		**37,655**	**29,324**
Current liabilities			
Trade and other payables	15	(33,692)	(28,341)
Borrowings	16	(58,529)	(12,153)
Provisions		(67)	(47)
Other liabilities		(1,933)	(1,207)
Total current liabilities		**(94,221)**	**(41,748)**
Total assets less current liabilities		**100,706**	**129,823**
Non-current liabilities			
Borrowings	16	(52,538)	(84,956)
Provisions		(744)	(111)
Total non-current liabilities		**(53,282)**	**(85,067)**
Total assets employed		**47,424**	**44,756**
Financed by			
Public dividend capital		74,065	69,113
Revaluation reserve		6,942	6,931
Income and expenditure reserve		(33,583)	(31,288)
Total taxpayers' equity		**47,424**	**44,756**

The notes on pages 112 to 134 form part of these accounts.

Name Dr Stephen Dunn CBE
Position Chief Executive Officer
Date 23 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**69,113**	**6,931**	**(31,288)**	**44,756**
Deficit for the year	-	-	(7,617)	**(7,617)**
Gain arising from transfers by modified absorption	-	-	8,531	**8,531**
Transfers by absorption: transfers between reserves	-	3,404	(3,404)	**-**
Impairments	-	(3,198)	-	**(3,198)**
Public dividend capital received	4,952	-	-	**4,952**
Other reserve movements	-	(195)	195	**-**
Taxpayers' and others' equity at 31 March 2020	**74,065**	**6,942**	**(33,583)**	**47,424**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**65,803**	**8,021**	**(19,972)**	**53,852**
Deficit for the year	-	-	(11,550)	**(11,550)**
Impairments	-	(264)	-	**(264)**
Revaluations	-	(592)	-	**(592)**
Public dividend capital received	3,310	-	-	**3,310**
Other reserve movements	-	(234)	234	**-**
Taxpayers' and others' equity at 31 March 2019	**69,113**	**6,931**	**(31,288)**	**44,756**

Information on reserves

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

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

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

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(4,234)	(9,463)
Non-cash income and expense:			
Depreciation and amortisation	6	7,259	6,139
Net impairments	7	7,903	5,506
Income recognised in respect of capital donations	4	(245)	(711)
Increase in receivables and other assets		(11,011)	(1,367)
(Increase) / decrease in inventories		(174)	14
Increase in payables and other liabilities		5,314	4,512
Increase / (decrease) in provisions		651	(63)
		5,463	**4,567**
Cash flows from investing activities			
Interest received		83	69
Purchase of intangible assets		(9,289)	(7,656)
Purchase of Property, Plant and Equipment		(12,173)	(21,043)
Sales of Property, Plant and Equipment		28	158
Receipt of cash donations to purchase assets		-	500
Net cash flows used in investing activities		**(21,351)**	**(27,972)**
Cash flows from financing activities			
Public dividend capital received		4,952	3,310
Increase in loans from DHSC		17,902	27,342
Repayment of loans from DHSC		(3,769)	(2,933)
Increase in other loans		218	623
Repayments of other loans		(280)	(243)
Capital element of finance lease rental payments		(1,884)	(1,120)
Interest on loans		(2,131)	(1,384)
Interest paid on finance lease liabilities		(279)	(213)
PDC dividend paid		(907)	(1,071)
Net cash flows from financing activities		**13,822**	**24,311**
Increase / (decrease) in cash and cash equivalents		**(2,066)**	**906**
Cash and cash equivalents at 1 April - brought forward		**4,507**	**3,601**
Cash and cash equivalents at 31 March	14	**2,441**	**4,507**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

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

Note 1.2 Going concern
After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. In addition, the Trust has a borrowing arrangement in place with the Department of Health and Social Care (DHSC) to support its liquidity position. If the Trust no longer existed health services funded by the DHSC would still be provided. For this reason, the Directors continue to adopt the going concern basis in preparing the accounts.

The control total for 2019/20 was achieved with an adjusted surplus of £102k reported.

During 2019/20 the Trust borrowed £17.9 million from the Department of Health and Social Care (DHSC). £8.2 million of this was for capital investment and £9.7 million for revenue support. It is probable that the Trust will require further borrowing in the next year to fund further capital projects.

The expectation is that income will be forthcoming from NHS England during 2020/21 in order to deliver the control total in the current climate. The Trust is forecasting to achieve a break even position in 2020/21 after taking into account the receipt of MRET and Provider Sustainability Funding.

Note 1.3 Interests in other entities
The Trust has a 25% share in Collaborative Procurement Partnership Limited Liability Partnership (LLP) with three other NHS Organisations. The LLP was established in 2017/18 and the investment in this is not yet material to the Trust. Therefore assets have not been reflected in the accounts. No income has been accrued for in 2019/20 as no profits are expected to be distributed (£359k in 2018/19). However a loss of £145k has been recognised due to the Trust not receiving the expected income from 2018/19.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	N/A	N/A
Buildings, excluding dwellings*	1	88
Dwellings	17	89
Plant & machinery	5	25
Transport equipment	10	10
Information technology	5	10
Furniture & fittings	10	10

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

* The minimum life of 1 year relates to Maple House, for which the Trust rents under a Finance Lease. This Lease has 1 year remaining of the lease term. If this was removed, the minimum life for a building would be 8 years.

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	7	20
Software licences	5	10

Note 1.9 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.11 Leases
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 a lessee
Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.
Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor
Operating leases

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

Note 1.12 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 18 but is not recognised in the Trust's accounts.

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

Note 1.13 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant 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 calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.14 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Transfers of former Primary Care Trust assets to NHS Providers
For former Primary Care Trust assets that have been transferred to the Trust from NHS Property Services, the transaction is accounted for using the modified absorption approach and the gain on transfer is recognised directly in reserves.

For property, plant and equipment assets, the cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within Public Sector accounts. Further details can be seen in note 23.

Note 1.16 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.17 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation. The Trust has already completed a review of all current lease arrangements in place in readiness for the implementation of this standard on 1 April 2021.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted. This is not expected to have a material impact on the Trust.

Note 1.18 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

• **Equipment Deposits**: The Trust pays a deposit to an external company for equipment issued to patients in the community. If the equipment is returned and the company is able to re-use it, the deposit is returned. Based on experience in the last 4.5 years it is assumed that 74% of deposits outstanding at the balance sheet date will be recovered, which equates to £8.4 million for 2019/20.

• **Valuation of Land & Buildings**: The Trust employs a professional Valuer to value all land and buildings and to estimate their useful economic lives which are used to calculate depreciation. Assets are revalued by the Valuer every five years and the last full valuation was undertaken in 2018/19. Every year the Trust requests that the Valuer considers the accuracy of this valuation and to apply an indexation to ensure that the value of land and buildings remains materially accurate.

For 2019/20 the Valuer has performed this exercise and, as a result of the current pandemic, has applied an indexation which has resulted in a reduction in value of the Trust's land and buildings. This is based on RICS guidance issued, which also highlights the uncertain impact of COVID-19 on the markets. The Valuer's report includes a material uncertainty statement over the valuation provided, this is due to the fact that, at the valuation date, less weight can be attached to previous market evidence for comparison purposes to inform opinions on value. As a result a higher degree of caution is attached to the year-end valuation as would normally be the case. The material uncertainty clause is to serve as a precaution and does not invalidate the valuation figures provided. The value of the Trust's land and buildings equates to £92.8m as at 31 March 2020. Further details can be found in note 12.

The Trust does not consider to have undertaken any critical judgements in applying accounting policies that do not involve the estimates noted above.

Note 2 Operating Segments

The Trust reports to the Board, which is considered to be the Chief Operating Decision Maker, on a monthly basis the performance at a divisional level. In considering segments with a total income of 10% or more of the Trust's total income. The Trust has identified five reportable segments. The main source of income for the Trust is from commissioners in respect of healthcare services from CCGs who are under common control and classified as a single customer. Net assets are not reported to the Board on a segmental basis therefore have been excluded for the purposes of this note.

The Trust reports to the Board by directorate down to an operating contribution.

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2019/20	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	87,173	62,294	22,814	48,386	39,842	22,664	283,173
Expenditure	(68,825)	(51,868)	(17,209)	(44,237)	(42,854)	(62,414)	(287,407)
Contribution	**18,348**	**10,426**	**5,605**	**4,149**	**(3,012)**	**(39,750)**	**(4,234)**

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2018/19	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	74,498	60,339	23,825	29,493	39,146	17,651	244,952
Expenditure	(62,598)	(51,062)	(16,418)	(28,166)	(37,653)	(58,518)	(254,415)
Contribution	**11,900**	**9,277**	**7,407**	**1,327**	**1,493**	**(40,867)**	**(9,463)**

These segments represent the management structure in the organisation.

This note analyses total income by management unit within the organisation. The following note analyses patient care and non patient care income separately. Please note that total income for Community services includes both patient care income and an element of the non patient care income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Acute services		
Elective income	32,737	32,916
Non elective income	79,411	63,739
First outpatient income	18,715	15,813
Follow up outpatient income	18,162	20,393
A & E income	11,422	9,092
High cost drugs income from commissioners (excluding pass-through costs)	14,110	14,352
Other NHS clinical income	19,705	11,700
Community services		
Community services income from CCGs and NHS England	28,041	26,805
Income from other sources (e.g. local authorities)	10,129	9,606
All services		
Private patient income	1,174	2,320
Agenda for Change pay award central funding*	-	2,435
Additional pension contribution central funding**	7,368	-
Other clinical income	602	552
Total income from activities	**241,576**	**209,723**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.38% to 20.68% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	26,964	14,235
Clinical commissioning groups	203,113	180,575
Department of Health and Social Care	-	2,435
Other NHS providers	8,493	8,300
Local authorities	1,230	1,306
Non-NHS: private patients	1,009	2,107
Non-NHS: overseas patients (chargeable to patient)	165	213
Injury cost recovery scheme	599	529
Non NHS: other	3	23
Total income from activities	**241,576**	**209,723**
Of which:		
Related to continuing operations	241,576	209,723

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20	2018/19
	£000	£000
Income recognised this year	165	213
Cash payments received in-year	132	196
Amounts added to provision for impairment of receivables	176	34
Amounts written off in-year	125	17

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	609	-	**609**	510	-	**510**
Education and training	7,326	-	**7,326**	7,601	-	**7,601**
Non-patient care services to other bodies	16,909	-	**16,909**	14,140	-	**14,140**
Provider sustainability fund (PSF)	4,419	-	**4,419**	7,014	-	**7,014**
Financial recovery fund (FRF)	1,823	-	**1,823**	-	-	-
Marginal rate emergency tariff funding (MRET)	4,153	-	**4,153**	-	-	-
Income in respect of employee benefits accounted on a gross basis	-	-	**-**	52	-	**52**
Receipt of capital grants and donations	-	245	**245**	-	711	**711**
Rental revenue from operating leases	-	125	**125**	-	120	**120**
Other income	5,988	-	**5,988**	5,081	-	**5,081**
Total other operating income	**41,227**	**370**	**41,597**	**34,398**	**831**	**35,229**
Of which:						
Related to continuing operations			**41,597**			**35,229**

Other income includes £2m car parking (2018/19 £1.8m) and £1.7m catering income (2018/19 £1.7m).

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	241,576	209,723
Income from services not designated as commissioner requested services	41,597	35,229
Total	**283,173**	**244,952**

Note 6 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	89	232
Purchase of healthcare from non-NHS and non-DHSC bodies	1,596	1,126
Staff and executive directors costs	184,595	162,669
Remuneration of non-executive directors	119	114
Supplies and services - clinical (excluding drugs costs)	32,863	29,531
Supplies and services - general	4,603	3,064
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,033	21,140
Inventories written down	265	133
Consultancy costs	458	153
Establishment	4,550	2,866
Premises	5,492	4,816
Transport (including patient travel)	2,012	2,182
Depreciation on property, plant and equipment	4,972	4,486
Amortisation on intangible assets	2,287	1,653
Net impairments	7,903	5,506
Movement in credit loss allowance: contract receivables / contract assets	102	49
Increase/(decrease) in other provisions	32	-
Audit fees payable to the external auditor		
audit services- statutory audit*	45	54
other auditor remuneration (external auditor only)	-	5
Internal audit costs**	119	144
Clinical negligence	6,987	7,315
Legal fees	315	145
Insurance	124	170
Education and training	805	558
Rentals under operating leases	4,484	5,819
Car parking & security	357	263
Hospitality	21	26
Losses, ex gratia & special payments	100	42
Other	79	154
Total	**287,407**	**254,415**
Of which:		
Related to continuing operations	287,407	254,415

* The audit fees disclosed are gross of VAT in 2018/19. The net figure is £45k for the statutory audit. The audit fees for 2019/20 are shown net of VAT.

** All internal audit costs are non-staff related as the service is provided by an external firm.

Note 6.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	9	-
Changes in market price	5,647	4,184
Other	2,247	1,322
Total net impairments charged to operating surplus / deficit	**7,903**	**5,506**
Impairments charged to the revaluation reserve	3,198	264
Total net impairments	**11,101**	**5,770**

Impairments arose in 2019/20 as a result of a revaluation exercise carried out at the end of the year. The Valuer has reviewed the value of the Trust's land and buildings and a reduction in asset value has occurred as follows:

	Impairment
	£000
Main Hospital Block	7,155
Land	2,593
Other Buildings	1,353
Total	**11,101**

The changes in market price relates to the main hospital block and is a write down as a result of newly constructed assets coming into use. This related specifically to AAU, Labour Suite and the Cath Lab.
The remainder of the impairment relates to the impact of the current pandemic on the markets. This is based on guidance issued by the Royal Institute of Chartered Surveyors (RICS), which also highlights the uncertain impact of COVID-19 on the markets. The Valuer's report includes a material uncertainty statement over the valuation provided, this is due to the fact that, at the valuation date, less weight can be attached to previous market evidence for comparison purposes to inform opinions on value. See note 12.4 for details.

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	143,039	131,472
Social security costs	14,160	12,984
Apprenticeship levy	696	635
Employer's contributions to NHS pensions*	25,137	15,595
Pension cost - other	51	31
Temporary staff (including agency)	5,792	5,188
Total gross staff costs	**188,875**	**165,905**
Recoveries in respect of seconded staff	-	-
Total staff costs	**188,875**	**165,905**
Of which		
Costs capitalised as part of assets	4,280	3,236

Remuneration of non-executive Directors is excluded from this note and is disclosed separately in note 6.

* The employer pension contribution increased from 14.38% in 2018/19 to 20.68% in 2019/20.

Note 8.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £35k (£14k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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.

Note 10 Operating leases

Note 10.1 West Suffolk NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where West Suffolk NHS Foundation Trust is the lessee.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	4,484	5,819
Total	**4,484**	**5,819**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,257	1,050
- later than one year and not later than five years;	1,321	1,465
- later than five years.	8	9
Total	**2,586**	**2,524**
Future minimum sublease payments to be received	-	-

The lease costs in this note include properties on licence from NHS Property Services used for the delivery of community services. No leases have been signed for in relation to these properties so £0 has been included in future commitments. The remaining leases relate to vehicles and equipment.

Note 11 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**1,490**	**45,545**	**-**	**47,035**
Additions	-	33	9,256	**9,289**
Reclassifications	-	-	-	**-**
Valuation / gross cost at 31 March 2020	**1,490**	**45,578**	**9,256**	**56,324**
Amortisation at 1 April 2019 - brought forward	**62**	**13,003**	**-**	**13,065**
Provided during the year	66	2,221	-	**2,287**
Reclassifications	6	(6)	-	**-**
Amortisation at 31 March 2020	**134**	**15,218**	**-**	**15,352**
Net book value at 31 March 2020	**1,356**	**30,360**	**9,256**	**40,972**
Net book value at 1 April 2019	**1,428**	**32,542**	**-**	**33,970**

Note 11.1 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**1,490**	**29,900**	**3,874**	**35,264**
Additions	-	11,771	-	**11,771**
Reclassifications	-	3,874	(3,874)	**-**
Valuation / gross cost at 31 March 2019	**1,490**	**45,545**	**-**	**47,035**
Amortisation at 1 April 2018 - as previously stated	**-**	**11,412**	**-**	**11,412**
Provided during the year	62	1,591	-	**1,653**
Amortisation at 31 March 2019	**62**	**13,003**	**-**	**13,065**
Net book value at 31 March 2019	**1,428**	**32,542**	**-**	**33,970**
Net book value at 1 April 2018	**1,490**	**18,488**	**3,874**	**23,852**

Note 12 Property, plant and equipment - 2019/20

	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**7,722**	**74,387**	**10,828**	**2,408**	**15,802**	**4**	**7,049**	**135**	**118,335**
Transfers by absorption	2,771	6,921	-	-	-	-	-	-	**9,692**
Additions	-	4,647	-	5,795	2,249	-	2,230	-	**14,921**
Impairments	(640)	(10,451)	(10)	-	-	-	-	-	**(11,101)**
Revaluations	(1,953)	(2,002)	(210)	-	-	-	-	-	**(4,165)**
Reclassifications	-	735	82	(1,373)	(134)	-	690	-	**-**
Disposals / derecognition	-	-	-	-	(173)	-	(7)	-	**(180)**
Valuation/gross cost at 31 March 2020	**7,900**	**74,237**	**10,690**	**6,830**	**17,744**	**4**	**9,962**	**135**	**127,502**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**55**	**-**	**-**	**10,211**	**4**	**4,733**	**109**	**15,112**
Transfers by absorption	-	1,161	-	-	-	-	-	-	**1,161**
Provided during the year	-	2,765	183	-	1,350	-	665	9	**4,972**
Revaluations	-	(3,982)	(183)	-	-	-	-	-	**(4,165)**
Reclassifications	-	1	-	-	(1)	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(164)	-	(7)	-	**(171)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**11,396**	**4**	**5,391**	**118**	**16,909**
Net book value at 31 March 2020	**7,900**	**74,237**	**10,690**	**6,830**	**6,348**	**-**	**4,571**	**17**	**110,593**
Net book value at 1 April 2019	**7,722**	**74,332**	**10,828**	**2,408**	**5,591**	**-**	**2,316**	**26**	**103,223**

Note 12.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**6,850**	**69,554**	**3,415**	**8,871**	**14,898**	**4**	**6,405**	**135**	**110,132**
Additions	-	6,231	9,676	2,292	1,252	-	498	-	**19,949**
Impairments	-	(3,240)	(2,693)	-	-	-	-	-	**(5,933)**
Revaluations	872	(6,229)	(102)	-	-	-	-	-	**(5,459)**
Reclassifications	-	8,071	532	(8,755)	6	-	146	-	**-**
Disposals / derecognition	-	-	-	-	(354)	-	-	-	**(354)**
Valuation/gross cost at 31 March 2019	**7,722**	**74,387**	**10,828**	**2,408**	**15,802**	**4**	**7,049**	**135**	**118,335**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**2,325**	**92**	**-**	**9,215**	**4**	**4,226**	**100**	**15,962**
Provided during the year	-	2,576	92	-	1,302	-	507	9	**4,486**
Impairments	-	(163)	-	-	-	-	-	-	**(163)**
Revaluations	-	(4,683)	(184)	-	-	-	-	-	**(4,867)**
Disposals / derecognition	-	-	-	-	(306)	-	-	-	**(306)**
Accumulated depreciation at 31 March 2019	**-**	**55**	**-**	**-**	**10,211**	**4**	**4,733**	**109**	**15,112**
Net book value at 31 March 2019	**7,722**	**74,332**	**10,828**	**2,408**	**5,591**	**-**	**2,316**	**26**	**103,223**
Net book value at 1 April 2018	**6,850**	**67,229**	**3,323**	**8,871**	**5,683**	**-**	**2,179**	**35**	**94,170**

Note 12.2 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	7,900	70,063	10,690	6,830	1,263	-	4,251	-	**100,997**
Finance leased	-	11	-	-	4,320	-	285	-	**4,616**
Owned - donated	-	4,163	-	-	765	-	35	17	**4,980**
NBV total at 31 March 2020	**7,900**	**74,237**	**10,690**	**6,830**	**6,348**	**-**	**4,571**	**17**	**110,593**

Note 12.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	7,722	70,330	10,828	2,408	1,565	-	1,766	-	**94,619**
Finance leased	-	444	-	-	3,284	-	486	-	**4,214**
Owned - donated	-	3,558	-	-	742	-	64	26	**4,390**
NBV total at 31 March 2019	**7,722**	**74,332**	**10,828**	**2,408**	**5,591**	**-**	**2,316**	**26**	**103,223**

Note 12.4 Revaluations of property, plant and equipment

A valuation exercise on the land an properties comprising the West Suffolk NHS Foundation Trust estate was carried out with a valuation date of 31 March 2020. This valuation was undertaken by an external Valuer, by Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'). In preparing the valuation, the Valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the Valuer having declared this material valuation uncertainty, the Valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Property, Plant and Equipment on the Statement of Financial Position has a carrying amount of £110.6m. Within this, £92.8m is considered to be specialised property which is valued on a depreciated replacement cost basis. This includes the hospital site and residences. Here the Valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

The key assumptions that are most likely to affect the valuations are:

- **Cost data**: The Valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the Valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher this would have an impact on the value of specialised properties recorded in the balance sheet of an increase of £4.2 million.

- **Adjustments for obsolescence**: Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the Valuer based on his knowledge and experience, it takes into account physical deterioration, functional obsolescence and economic obsolescence. Had the adjustment for obsolescence been 2% higher than the Valuer assumed, this would have an impact on the value of specialised properties recorded in the balance sheet of a decrease of £3.6 million.

The valuer also reviewed the useful economic lives of the Trust buildings. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives by category of asset are detailed in note 1.7.

Note 13 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	27,087	17,475
Allowance for impaired contract receivables / assets	(211)	(216)
Deposits and advances	3,323	2,815
Prepayments (non-PFI)	916	942
PDC dividend receivable	137	127
VAT receivable	1,015	900
Corporation and other taxes receivable	75	76
Total current receivables	**32,342**	**22,119**
Non-current		
Deposits and advances	5,041	5,054
Other receivables	666	-
Total non-current receivables	**5,707**	**5,054**
Of which receivable from NHS and DHSC group bodies:		
Current	22,912	13,277
Non-current	666	-

Note 13.1 Exposure to credit risk

	31 March 2020 £000	31 March 2019 £000
Ageing of impaired financial assets		
90- 180 days	44	42
Over 180 days	167	174
Total	**211**	**216**

	31 March 2020 £000	31 March 2019 £000
Ageing of non-impaired financial assets past their due date (not including accruals)		
0 - 30 days	3,650	3,749
30-60 Days	253	398
60-90 days	578	214
90- 180 days	1,262	664
Over 180 days	1,203	1,709
Total	**6,946**	**6,734**

£5.9 million of the non-impaired financial assets past their due date are owed by NHS organisations.

Note 14 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20 £000	2018/19 £000
At 1 April	**4,507**	**3,601**
Net change in year	(2,066)	906
At 31 March	**2,441**	**4,507**
Broken down into:		
Cash at commercial banks and in hand	8	62
Cash with the Government Banking Service	2,433	4,445
Total cash and cash equivalents as in SoCF	**2,441**	**4,507**

Note 15 Trade and other payables

	31 March 2020	31 March 2019
Current		
Trade payables	10,738	7,995
Capital payables	2,860	2,097
Accruals	13,444	12,470
Social security costs	2,166	1,938
Other taxes payable	1,621	1,532
Other payables	2,863	2,309
Total current trade and other payables	**33,692**	**28,341**
Of which payables from NHS and DHSC group bodies:		
Current	6,472	5,755

Note 16 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC*	56,478	10,319
Other loans	332	281
Obligations under finance leases	1,719	1,553
Total current borrowings	**58,529**	**12,153**
Non-current		
Loans from DHSC	45,074	77,069
Other loans	2,414	2,527
Obligations under finance leases	5,050	5,360
Total non-current borrowings	**52,538**	**84,956**

* The balance for current loans from DHSC includes £46.6m of interim revenue and capital loans which will be converted to PDC during 2020/21.

Note 16.1 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**87,388**	**2,808**	**6,913**	**97,109**
Cash movements:				
Financing cash flows - payments and receipts of principal	14,133	(62)	(1,884)	**12,187**
Financing cash flows - payments of interest	(2,026)	(105)	(279)	**(2,410)**
Non-cash movements:				
Additions	-	-	1,740	**1,740**
Application of effective interest rate	2,057	105	279	**2,441**
Carrying value at 31 March 2020	**101,552**	**2,746**	**6,769**	**111,067**

Note 16.2 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**62,790**	**2,428**	**3,287**	**68,505**
Cash movements:				
Financing cash flows - payments and receipts of principal	24,409	380	(1,120)	**23,669**
Financing cash flows - payments of interest	(1,289)	(95)	(213)	**(1,597)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	125	-	-	**125**
Additions	-	-	4,746	**4,746**
Application of effective interest rate	1,353	95	213	**1,661**
Carrying value at 31 March 2019	**87,388**	**2,808**	**6,913**	**97,109**

Note 17 Finance leases

Note 17.1 West Suffolk NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**6,769**	**6,913**
of which liabilities are due:		
- not later than one year;	1,719	1,553
- later than one year and not later than five years;	5,050	5,070
- later than five years.	-	290
Net lease liabilities	**6,769**	**6,913**

	31 March 2020 £000	31 March 2019 £000
Mininum lease payments		
Within one year	2,490	2,147
Between one and two years	3,705	2,128
Between two and five years	3,304	6,864
More than five years	0	619
	9,499	11,758
Future finance lease capital	(1,000)	(3,438)
Finance charges allocated to future periods	(1,730)	(1,407)
Net lease liabilities	**6,769**	**6,913**

All finance leases relate to equipment. In 2018/19 the Trust entered into a seven year lease arrangement for Cerner applications and services. The current capitalisable value is £3.2m (£4.1m in 2018/19).

Note 18 Clinical negligence liabilities

At 31 March 2020, £101,138k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2019: £88,659k).

Note 19 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	4,905	1,618
Intangible assets	9,988	9,411
Total	**14,893**	**11,029**

Note 20 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2020	31 March 2019
	£000	£000
Not later than 1 year	2,403	2,434
After 1 year and not later than 5 years	3,503	5,905
Paid thereafter	273	273
Total	**6,179**	**8,612**

Note 21 Carrying values of financial assets

	31 March 2020	31 March 2019
Carrying values of financial assets as at 31 March 2020	**Held at amortised cost**	**Held at amortised cost**
	£000	£000
Trade and other receivables excluding non financial assets	36,117	25,344
Cash and cash equivalents	2,441	4,507
Total	**38,558**	**29,851**

£23.6m of the Trust's financial assets relate to income owed from other NHS Organisations (2018/19: £13.1m). Of the remaining balance as at 31 March 2020, £8.4m relates to desposits recoverable when community equipment is returned based on the likely proportion that will be returned.

The remainder of the balance is money owed from non-NHS Organisations. The collection of this debt is monitored closely and the balance is impaired or written off when the collection looks unlikely.

There are no individually material debts owed by non-NHS Organisations and the risk profile of the asset is assessed as low, which is the same as in 2018/19.

Note 21.1 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	31 March 2020 Held at amortised cost £000	31 March 2019 Held at amortised cost £000
Loans from the Department of Health and Social Care	101,552	87,388
Obligations under finance leases	6,769	6,913
Other borrowings	2,746	2,808
Trade and other payables excluding non financial liabilities	29,905	24,871
Provisions under contract	39	23
Total at 31 March 2020	**141,011**	**122,003**

Borrowing excluding finance leases is at a fixed rate and, apart from £2.7m from a commercial loan provider, is from the Department of Health and Social Care.

Within trade and other payables excluding non financial liabilities, £6.5m (2018/19: £5.7m) relates to liabilities with other NHS organisations.

There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as in 2018/19.

Note 21.2 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	88,481	37,161
In more than one year but not more than two years	5,709	12,997
In more than two years but not more than five years	9,997	26,604
In more than five years	36,824	45,241
Total	**141,011**	**122,003**

Note 21.3 Fair values of financial assets and liabilities

The fair value of the financial instruments is based on book value (carrying value) because this is not considered to be significantly different to the initial transactions recognised.

Note 22 Related parties

	Income		Expenditure	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
East Suffolk and North Essex NHS Foundation Trust	10,932	8,605	6,933	4,918
Ipswich Hospital NHS Trust	-	2,163	-	93
NHS West Suffolk CCG	161,694	145,394	264	91
NHS Ipswich And East Suffolk CCG	22,217	18,336	26	1
NHS South Norfolk CCG	16,181	14,682	2	-
NHS Cambridgeshire and Peterborough CCG	3,163	2,901	0	23
Health Education England	7,082	7,507	93	22
NHS England	32,894	20,768	94	103
NHS Resolution (formerly NHS Litigation Authority)	0	0	7,216	7,482
NHS Property Services	207	103	1,300	2,412
Department of Health and Social Care	0	2,475	3	8
Total	**254,370**	**222,934**	**15,931**	**15,153**

	Receivables		Payables	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
East Suffolk and North Essex NHS Foundation Trust	1,129	646	1,253	1,464
Ipswich Hospital NHS Trust	-	-	-	-
NHS West Suffolk CCG	2,760	1,250	1,130	1,099
NHS Ipswich and East Suffolk CCG	188	283	-	45
NHS South Norfolk CCG	297	1,232	153	124
NHS Cambridgeshire and Peterborough CCG	-	-	43	183
Health Education England	30	-	100	62
NHS England	15,090	5,387	23	28
NHS Resolution (formerly NHS Litigation Authority)	-	-	60	4
NHS Property Services	282	75	2,647	2,068
Department of Health and Social Care	-	-	-	3
Total	**19,776**	**8,873**	**5,409**	**5,080**

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent £245k on behalf of the Trust on capital items plus a further £292k on revenue items (2018/19: £711k on capital items plus a further £462k on revenue items). At the year end the Charity owed the Trust £85k (2018/19 £169k).

The Trust has disclosed transactions with NHS bodies where the income, expenditure, receivable or payable balance is over £2 million.

Note 23 Modified transfer by absorption

On 1 October 2020 the ownership of Newmarket Hospital was transferred to the Trust from NHS Property Services. Newmarket Hospital was a former Primary Care Trust asset and therefore the transfer of ownership has been accounted for via a modified absorption approach, in accordance with the GAM. The gain on the transfer of £8.5m has been recognised directly in reserves. The transfer of accumulated depreciation and revaluation reserves has also been recognised. The balances are as follows:

	£000
Gross book value on transfer	9,692
Accumulated Depreciation	(1,161)
Gain on transfer	**8,531**
Revaluation Reserve	(3,404)
Overall impact on I&E reserve	**5,127**

Note 24 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans will be extinguished via conversion to Public Dividend Capital (PDC). This creates an adjusting post balance sheet event.

Outstanding interim loans totalling £46.6m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.