NHS
West Suffolk
NHS Foundation Trust

Annual report and accounts

2020/21

Putting you first

West Suffolk NHS Foundation Trust

Annual Report and Accounts 2020/21

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

At this time last year no-one could have foreseen the true extent of the challenges that the NHS, the nation and the world would have to face from coronavirus. In the first wave west Suffolk experienced a comparatively low rate of infection and hospitalisation, but this still put a great strain on our staff and services throughout the Trust as we quickly adapted to caring for patients in urgent need.

In the winter we experienced the second wave, with many more people succumbing to the virus and needing to be cared for in the hospital and in the community. The number of patients in our critical care facilities and on wards stretched our staff and services to the limit. At the same time our community staff were looking after patients in care facilities and their own homes, from the first days of their lives to those nearing the end, and often the most vulnerable.

There was the added pressure of staff sickness, illness in the family and the requirement to self-isolate, which further strained the resources of colleagues doing all they could, as always, for those who needed them. Retired professionals returned to work and others were willingly redeployed to help hard-pressed teams. People worked extra shifts and long hours and some even left their young families so they could continue to care for our patients. Everyone, in every role went above and beyond to serve our community and it has been truly humbling to be part of our west Suffolk team.

We adopted new ways of working to minimise transmission of the virus, and learned the true value of digital communication to stay in touch with patients and colleagues we could not see face to face. From December we were able to support the nationwide vaccination programme, and more than 100 staff volunteered to help protect both Trust colleagues and those in partner health and social care organisations. More than 32,000 vaccines have been delivered, an achievement recognised with an award from the Lord Lieutenant of Suffolk.

Of course, our dedicated and hardworking colleagues are our greatest asset, and we have worked hard this year to listen to what they have to say and take action to improve our culture and their working lives. Our ‘What Matters to You’ staff survey received 1,400 responses and gave us clear direction to focus in five areas:

- Importance of great line managers
- Creating an empowered culture
- Building relationships and belonging
- Appreciating all our staff
- The future and recovery.

The annual NHS staff survey published earlier this year gave us more information and showed a reduction in most of our scores, although many remain well above the average for organisations like ours. In some areas the reductions are small, in others they are more significant. This is concerning and means it’s more important than ever to use the feedback we get from staff to learn and make improvements together.

In response to the pandemic and the impact it has had on our staff, we increased our focus on the wellbeing of all our colleagues, with a range of initiatives and opportunities to support their mental and physical health. We have been very clear with one central message – it’s OK to be not OK. We have expanded our staff psychology support service and the team has had contact with over 10% of our workforce. We have run events and provided resources to help staff know they are supported. We

have raised the profile of our Freedom to Speak Up guardians as part of a drive to develop a more open and transparent culture.

The focus on improving our culture continues, including learning from best practice around the UK, such as the work of Civility Saves Lives, a group of healthcare professionals aiming to raise awareness of the power of being civil in healthcare settings. The messages from this are that our working lives and patient care are improved by great teamwork and the importance of feeling safe to raise a concern. Ten of our leaders have been attending the Northumbria University and Mersey Care NHS Foundation Trust programme, 'Transforming Organisational Culture - Principles and Practice of Restorative Just Culture' – another inspiring source of learning we can bring to our Trust.

Looking to the future, we have updated and evolved our integrated quality and performance report (IQPR) and highlighted the progress of our Trust improvement plan. At the same time, we are reviewing our strategy and values to give us a roadmap that will take us forward. Our new Trust strategy will be launched later this year, focusing on three ambitions: First for Patients; First for Staff and First for the Future.

We can indeed look forward to the future, as the West Suffolk Hospital has been confirmed as one of 40 hospitals to benefit from a £3.7bn building programme. Our hospital is ageing and, with the support of our committed estates team, we have been dealing with ongoing structural issues, as it will of course be a number of years before our new hospital is built. We have purchased Hardwick Manor and adjoining land as our preferred site. Meanwhile we are developing a comprehensive Future System programme to engage with people across Suffolk to ensure they can express their views and we can truly co-produce our new healthcare facility. Of course, healthcare does not just revolve around a hospital, and the Future System project also prioritises finding the most effective ways to provide joined-up care with public service organisations in the best setting for patients and their families. Through our partnerships in the Suffolk Alliances we have learned a great deal about meeting individual needs and providing wraparound care, so that many patients can be cared for in their own homes rather than in the acute hospital.

The development of public service hubs around west Suffolk shows us the way forward, bringing together leisure facilities as well as the NHS, social care and other providers. Our community colleagues are at the forefront of this integrated working – they are a vital part of the Trust team - and we will continue to drive forward this joined-up, patient-centred approach.

As we start to return to more normal lives, we are making every effort to tackle our waiting lists, which have increased due to the demands of coronavirus. We fully appreciate the anxiety this has caused for the many people who are waiting for treatment. We are putting in place a recovery programme that allows us to prioritise care for those in greatest need, and we are committed to doing everything we can to alleviate the delay.

As we look back on a year that has seen great suffering, and yet such inspiring examples of courage, determination and self-sacrifice, we mourn all those we have lost. The rollout of the vaccination programme and declining infection rates give us cause to hope for better days to come, but we cannot afford to be complacent. COVID-19 remains a real and present danger and we are still at risk. We must continue to do all we can to minimise the spread of the virus. Hands, face, space and fresh air remain important. COVID-19 is running rife in many countries and many of our staff have loved ones in those nations – we stand with them and assure them of our support.

The year to come will doubtless bring new challenges, but having witnessed the extraordinary efforts of our colleagues and our community in past months, we can face the future with pride and optimism.

Sheila Childerhouse
Chair
29 June 2021

Dr Stephen Dunn CBE
Chief executive
29 June 2021

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.

Work is currently underway to refresh the Trust Strategy with a view to simplifying the way we frame and communicate our vision and ambitions to our stakeholders. The revised strategy will be published in 2021.

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. Ongoing structural repairs to WSH continue to impact on this capacity. Access to specialist services is offered to local residents by WSFT networking with tertiary (specialist) centres, most notably Addenbrooke's and Royal Papworth hospitals. The Trust operates a streaming service embedded and co-located within the emergency department. Patients who attend the emergency department during the operating hours of the streaming service are assessed and directed to either the emergency department or the primary care unit, meaning they access the service that best addresses their healthcare need.

A range of nursing and therapy services are provided by our community health teams and specialist community teams; these services are provided in patients' own homes, health clinics/centres and community buildings, including a clinical assessment and prescribing service for a county-wide community wheelchair and equipment service, working with community therapists and a community neurological nurse specialist. We also have responsibility for Newmarket Community 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 Community Hospital as a base. Oakfield GP surgery is also based at the site.

Glastonbury Court is a care home in Bury St Edmunds run by Care UK. The Trust has commissioned a 20-bedded unit to provide ongoing assessment and reablement to patients who are medically optimised 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 various sites in Newmarket, Botesdale, Thetford, Stowmarket, Haverhill, Sudbury, Needham Market and Watton. This includes outpatient clinics and some diagnostic imaging – Newmarket Community Hospital (X-ray), Sudbury

Community Health Centre (X-ray) and Thetford Healthy Living Centre (ultrasound and X-ray). Linked to our early intervention team (EIT), we also have in place a 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 Community Hospital, Sudbury Community Health Centre, Haverhill Health Centre, Forbes Business Centre and Bury St Edmunds.

The Trust is also responsible for, through a contract with 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 services for lymphoedema and pain.

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

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

Our staff

We are one of the largest employers in Suffolk, employing 4,748 staff as of April 2021.

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

Our partners

The Trust works closely with other public, private and voluntary stakeholders. These include 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 subsequently plans to improve the health and care of our local people and bring the system back into a financially sustainable position. Our partnership includes all NHS organisations within the footprint including the ambulance service, local government, other health sector bodies, local hospices and community and voluntary sector organisations. Leadership for the ICS is drawn from across these stakeholders.

Going concern

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

1.2 Performance analysis

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

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

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

1.2.1 Performance management framework

The Trust has a board assurance framework (BAF) in place that sets out the principal risks to the delivery of the Trust's strategic 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 England / Improvement, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the council of governors.

Engagement and measurement:

- Quality walkabouts, including executive directors, non-executive directors and governors, have not been possible due to the social distancing requirements of COVID-19. Executives, non-executives and governors have engaged with staff through virtual meetings, including the regular all staff briefing
- External regulatory and assessment body inspections and reviews, including royal colleges, post-graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports
- Benchmarking for clinical indicators

- The work of clinical audit, which within its scope includes national audits, audits arising from national guidance such as the National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics.

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

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

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

In the most recent assessment report (published 30 January 2020) inspectors said staff: *"treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care".*

A structured improvement plan was put into place following the inspection and WSFT works in partnership with the West Suffolk CCG to provide an assurance framework to oversee its delivery. During 2020/21 this was managed via an improvement programme board which enabled oversight of action completion and a move to a 'business as usual' with appropriate assurance on embedded improvement.

Our services

We provide a range of patient services:

Indicators	2020/21	2019/20	2018/19	2017/18	2016/17
Inpatient planned	**1,722**	3,475	3,548	3,730	3,917
Inpatient non-planned	**29,623**	32,374	32,832	32,505	33,174
Day cases	**18,747**	32,815	31,696	30,824	30,105
Outpatient attendances (inc. ward attenders)	**234,464**	271,316	266,157	249,460	239,413
Outpatient procedures	**37,749**	79,570	79,404	82,880	87,474
ED attendances	**64,764**	78,822	74,400	70,918	67,176

The COVID-19 pandemic led to a reduction in patients seen across services in 2020/21. The focus during the initial outbreak and the subsequent peaks was to treat emergency patients with and without COVID-19 and to continue running cancer and urgent services. This also led to several services being adapted so patients could continue to be treated, with over 45% of outpatient appointments being undertaken virtually.

In 2020/21 our community teams in the west of Suffolk have received 54,000 new referrals, more than 190,000 face to face patient contacts, 92,000 telephone/video contacts and delivered 15,600 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 recorded a surplus of £0.2 million for the year 2020/21. Due to COVID-19 we received top up payments of £24.8m which is included in this position.

We have also been reimbursed for all COVID-related expenditure (including vaccination costs), shortfalls against non-clinical income receipts as a result of COVID and costs relating to annual leave carried forward to support a breakeven position.

	2020/21 £000s	2019/20 £000s	2018/19 £000s	2017/18 £000s	2016/17 £000s
Operating income	**321,282**	283,173	244,952	252,778	254,933
Operating costs	**(307,751)**	(272,245)	(242,770)	(245,906)	(251,016)
EBITDA * surplus/(deficit)	**13,531**	10,928	2,182	6,872	3,917
Depreciation, dividend and other costs	**(12,767)**	(10,642)	(8,226)	(7,159)	(6,961)
Fixed asset impairments**	**(1,496)**	(7,903)	(5,506)	0	(4,815)
Retained earnings	**(732)**	(7,617)	(11,550)	(287)	(7,859)

* 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

We employ more than 5,000 staff in both hospital and community healthcare settings and what they have achieved this year has been truly inspiring. The challenges of working in the NHS through a pandemic, while dealing with the restrictions we have all faced, has made doing all we can to support staff wellbeing more important than ever.

As part of our well-being programme, we have expanded our staff psychology support service allowing the team to offer one to one support as well as briefings for all through our Wellbeing Wednesday sessions, looking in depth at issues affecting many people. A partnership with Abbeycroft Leisure has given our employees free access to online and in-person sports facilities close to their homes, and has seen about 1,500 members of staff signing up. In February the communications team organised ‘Love Yourself’, a week of online wellbeing events from Pilates to cooking. All of these sessions were recorded so they could be watched at any time by our busy colleagues and there have been over 1,000 viewings.

We have also provided the tools for those colleagues who were able to work from home, allowing them to stay in touch with their colleagues and the rest of the Trust. Weekly virtual all-staff briefings have allowed us to keep people informed and address concerns they may have. We have ensured

our teams have the equipment they need to protect themselves, and introduced stringent processes to minimise transmission of the virus. Staff have also been able to access free hot drinks, hot food at night and free car parking.

Our My WiSH Charity is celebrating its 25th anniversary this year, and the dedicated team has worked tirelessly throughout the pandemic. From welfare packs for staff who need them, to calm spaces where people can take a break, they have provided practical help and support. Having helped fund major projects such as the development of Rainbow Ward and the cardiac centre, My WiSH Charity has been an incredible part of our Trust. Recently they have funded a registered play specialist who helps our youngest patients feel safe and reassured when they come into hospital.

Our WSFT workforce is a diverse one, and we strive to reflect this with a number of networks that help us meet the individual needs of all those who work for us. Our LGBT+ and disability networks were joined this year by a Black and Minority Ethnic network – we look forward to learning from these colleagues in the future.

Within our trust improvement programme, improving our culture is a priority, especially in the wake of a disappointing Care Quality Commission (CQC) report last year. Our CQC improvement plan has included a greater focus on encouraging people to feel able to speak up on matters of concern to them. These are some of the principles of the Civility Saves Lives project and Mersey Care Just Culture training which we have taken on board and learnt from over the last year.

We are early adopters of the new national Patient Safety Incident Response Framework, which will update the way we respond to and investigate incidents. We are involved in the pilot run by NHS England with regional partners and commissioners, which we hope will be rolled out nationally when the pilot comes to an end. As part of introducing the framework, the Trust's patient safety team is developing an incident response plan which will help us identify the most significant patient safety risks and ensure learning is put in place.

We have been joined this year by Natalie Bailey in the newly-created role of head of mental health. An experienced registered mental health nurse, Natalie will be working across the WSFT in both our hospitals and community services, and with partners and services.

Meanwhile our countywide community services continue to provide excellent care to people closer to their homes, whether that may be a speech and language therapist working in a special school or a district nurse helping to manage the pain relief for a patient at the end of their life. The integrated community teams, pathway one and enhanced support initiatives have proved the value of joined-up working, not just within the Trust but also with the wider system. Teaming up with social care and other providers has enabled us to provide improved care for patients, while also saving thousands of bed days at the hospital.

At our community hospital in Newmarket we have provided extra beds to help provide flexibility in the fight against COVID-19. We recruited new staff, including the first registered nursing associate at the Trust – a pioneering NHS role which contributes to the core work of nursing, supporting registered nurses to focus on more complex clinical care. The introduction of a portering team at the hospital has also improved the care we can offer patients and is proving a welcome support to staff.

At the West Suffolk Hospital, patients with COVID-19 or other infectious conditions can now be treated in specialist facilities at the new major assessment area within our emergency department. The 10-bed facility, made possible by a £2.7m Government grant, has separate treatment rooms designed to allow for isolation of patients while they are assessed.

To support our sustainability agenda, the My WiSH Charity provided free reusable cups to every staff member to cut down on waste and as a small ‘thank you’ for their work during the pandemic. The Trust also installed more LED lighting to save money and resources.

This year has seen demands made on our IT and digital teams as never before. As well as providing equipment and processes to enable staff to work from home, the IT team has supported clinical teams to use every digital platform available to keep in touch with patients. For example, our community cardiac rehabilitation team, unable to run their exercise classes, supported patients on Zoom.

This year has seen the transition of all our community colleagues onto the WSFT IT network, a project that has seen significant investment, both financially and in terms of time and expertise. Providing new digital equipment and smartphones and bringing these teams in line with their hospital-based colleagues has improved the working lives of staff across the Trust.

The West Suffolk community view in e-Care, our electronic patient record system, also known as the health information exchange, is now being widely used, most recently having been rolled out through our maternity services, and is a valuable tool in integrated working. Digital tools have helped us care for our patients and their families during the pandemic, when we have been forced to restrict visits from loved ones. We set up a Keeping in Touch and clinical helpline service to provide information and reassurance and keep patients in contact with their loved ones, and also introduced a free entertainment and media system that patients could use from a smartphone or tablet.

Despite the pandemic, a number of our services have achieved national recognition. Our stroke team retained its top grade A ranking for the ninth year in a row. Researchers at King's College London review data from hospitals across the country as part of the Sentinel Stroke National Audit Programme, assessing stroke care against 41 key indicators.

For the tenth successive year, the radiology department has been accredited with the Quality Standard in Imaging (QSI) by the United Kingdom Accreditation Service (UKAS). Another dedicated team received recognition for its work gathering and sharing data from our orthopaedic services. The award of National Joint Registry (NJR) Quality Data Provider for 2019/2020 demonstrates the high standards being met.

The community cardiac rehabilitation team met all seven key performance indicators to achieve accreditation from the British Association for Cardiovascular Prevention and Rehabilitation. This uses data from the National Audit of Cardiac Rehabilitation to quality assure services in the UK.

The Royal College of Physicians Joint Advisory Group on Endoscopy has awarded its highly-sought after professional accreditation to our endoscopy services, which use high-tech cameras to film inside the body to help with diagnosis and treatment.

Finally, our catering team received two accolades – the Health Business Awards Hospital Catering Award and recognition of the high quality of its food in a national report on catering in the NHS, led by Great British Bake Off judge Prue Leith.

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

After a challenging few years for colleagues in our pathology labs, we were pleased to welcome back to the Trust more than 100 pathology services staff, bringing the service in-house.

Our Trust continues to work in our wider community and with other system partners. With Glemsford Surgery, we have embarked on a special project to improve patient care, and have officially joined as integrated partners in healthcare. From the buildings to the staff, we will support the surgery and work together to create a new, innovative, strong and sustainable healthcare service in Glemsford and the west of Suffolk.

Partnerships such as this will prove more important as we develop our Future System programme, to deliver not only a new hospital, but sustainable and integrated healthcare for our community. As part of our plan to develop a new healthcare facility, we have purchased Hardwick Manor and have begun the process of planning and co-production. In the meantime, our estates team continues to work incredibly hard to make sure our current hospital remains fit for purpose until we can move into the healthcare facility.

Of course, in a year when COVID-19 has put the NHS under incredible strain, all of our staff have gone above and beyond to serve our community and look after those in the greatest need. As we look back, one of the key highlights of the last year has been the amazing team work across the Trust and the support and friendship given to one another.

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 2020/21 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 2.6).

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 2020/21, a total of 8,322 patient safety incidents were reported (compared with 8,008 in 2019/20). The Trust is an early adopter for the introduction of a new national patient safety incident response framework (PSIRF). The PSIRF is a key part of the NHS patient safety strategy published in 2019 and supports the strategy's aim to improve our understanding of safety by drawing insight from patient safety incidents.

Effective risk and performance management

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

Performance and quality improvement are connected from 'board to ward'. This is achieved through two-way communication between the Board 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 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 but these have been limited during the year due to COVID restrictions.

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 statement (section 2.5)
- Accounting policy note 1 (part of accounts).

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

Audit committee's review of the annual report and accounts

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

Social, community, anti-bribery and human rights issues

The West Suffolk NHS Foundation Trust, as 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 2020, 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 report was an abridged version of the normal process as a result of the pandemic. It did however allow greater focus on specific areas.

The substantial compliance level indicated that the Trust had a small 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, infrastructure risk management, and the COVID-19 pandemic has delayed this work.

1.2.4 Future business plans

1.2.4.1 Integrated care system (ICS)

West Suffolk Alliance is one of three place-based alliances that make up the Suffolk and North East Essex integrated Care System (ICS). The Alliance published its strategy in 2018 – All About People and Places - which established a shared set of ambitions which all alliance partners signed up to:

- 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**.

Since the inception of the West Suffolk Alliance:

- membership has grown and now encompasses partners from the NHS, local government, the voluntary, community and social enterprise sectors and others, to form a broad collaboration of organisations signed up to work together to deliver our strategy
- the Alliance has shown throughout the pandemic that the relationships between partners allow for rapid implementation of changes to services, the ability to develop a joint approach to problems and issues, and that partners are willing to innovate and use their resources flexibly to meet need
- learning from the pandemic is being used to inform our future direction, priorities and opportunities
- the NHS White Paper - Integrating Care - has reinforced the importance of 'place' as a building block for alliance working within a wider integrated care system footprint.

Our alliance delivery plan for 2021/22 has been developed with these points in mind. We have agreed that we want to have a plan that:

- demonstrates that we are working differently - as partners rather than as individual organisations - showing the added value of the Alliance
- highlights where we are delivering our alliance ambitions
- gives visibility to the range of transformation programmes going on within the West Suffolk Alliance area
- allows us to prioritise investment (financial and other resources)
- helps us develop as an alliance to meet future opportunities and challenges
- champions innovation
- shows how organisational priorities can be delivered through alliance working.

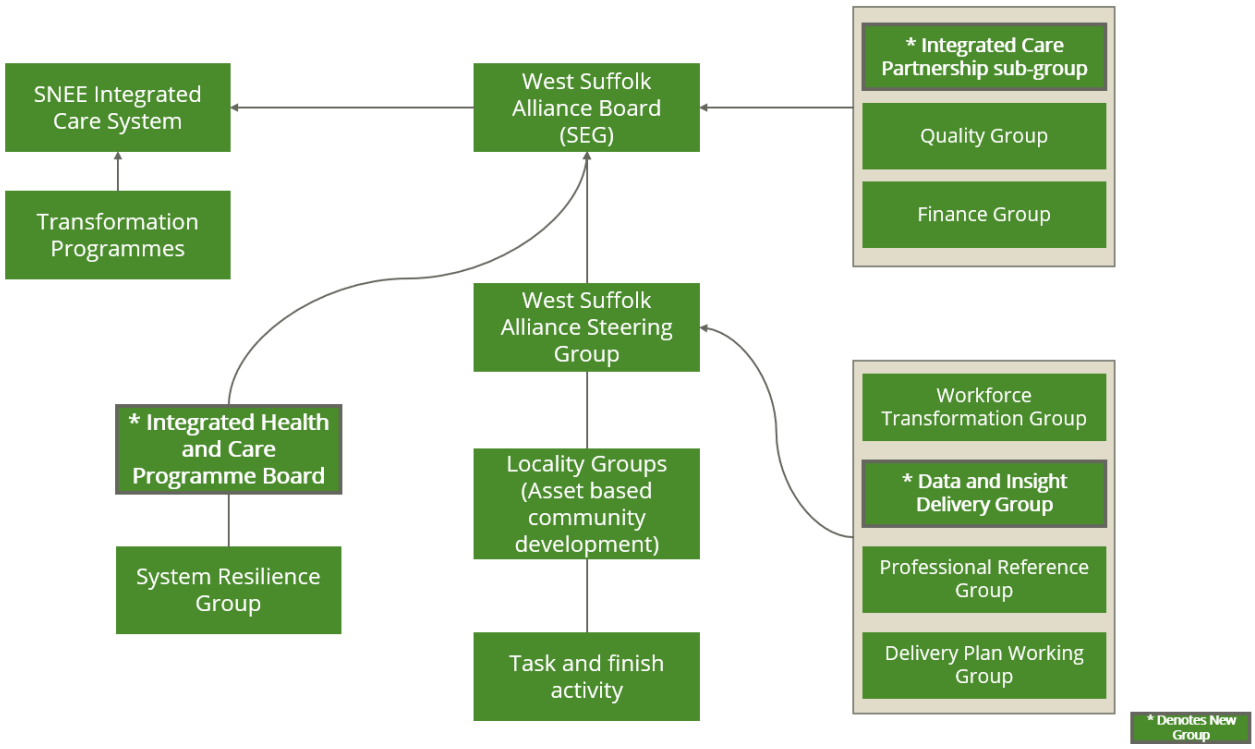
Actions include:

- building on our strategy to create a compelling mission and vision statement. The aim of this is to let people know what the Alliance is all about in a simple and straightforward way
- redesigning our governance to create a framework for action. This will mean a better understanding of where decisions are made and who holds accountability. Two new groups have been set up as part of the redesign to support health and care integration:
    - Integrate Care Partnership Sub-group – a smaller group of public service leaders responsible for shaping plans to formalise integration across health and local authorities, and consider how this could shape future integrated care partnerships in each alliance
    - Integrated Health and Care Programme Board – supporting the change programme that will deliver integrated care, allowing cross-divisional sharing of solutions and learning. The board will oversee the west implementation of the wider ICS transformation programmes, translating NHS priorities into place-based delivery
- creating a west Suffolk data and insight approach to better understand the complex challenges

facing citizens in west Suffolk and identify the emerging trends to inform strategic and operational decision making
- developing a systems communications function that focuses on joint work, celebrating success and ensuring that our teams feel the benefits of alliance working
- taking a system approach to inequalities, starting with the COVID-19 vaccination programme, and working to make sure that people most at risk, and from disadvantaged communities, get targeted support.

Alongside these actions there are many projects and initiatives across the partnership where alliance working is in action.

West Suffolk Alliance governance



Alliance partners

- Abbeycroft Leisure
- Allied Health Professionals Suffolk
- Babergh and Mid Suffolk District Councils
- Care UK
- Citizens Advice West Suffolk
- Community Action Suffolk
- Healthwatch
- Home-Start
- Local Pharmaceutical Committee
- Norfolk and Suffolk NHS Foundation Trust
- Primary care (24 GP surgeries)
- St. Nicholas Hospice
- Suffolk Constabulary
- Suffolk County Council
- Suffolk GP Federation
- Suffolk MIND
- West Suffolk Clinical Commissioning Group
- West Suffolk College
- West Suffolk District Council

- West Suffolk Foundation NHS Trust

1.2.4.2 Performance improvements and efficiency savings

The COVID-19 pandemic has significantly impacted upon the operational performance and efficiency of WSFT during 2020-21.

We have continued to operate our joint transformation team with West Suffolk CCG. However, members of the team were redeployed from planned programmes of work to address the challenges we faced in responding to the pandemic and implementing new ways of working to ensure that we could continue to treat patients safely.

Whilst it is true that many of the planned transformation programmes were put on hold, the pandemic also created opportunities for us to take forward a number of schemes at pace, which have been part of our longer-term ambitions for some time, such as increased use of digital platforms to support remote working and virtual consultations.

The West Suffolk Alliance partners came together to strengthen pre-existing relationships and enhance the offer to our communities through the integrated neighbourhood teams, and through working with the voluntary sector and organisations such as Abbeycroft Leisure.

As we look forward to the next year we are committed to embedding learning from the experience of working through the pandemic to enhance services for the future.

Elective accelerator programme

As part of the Suffolk & North East Essex (SNEE) Integrated Care System (ICS), WSFT has been successful in bidding to become an elective accelerator site. Acceptance onto the programme provides £10m of additional system funding, over and above the elective recovery fund (ERF), of which £1.6m has been allocated to WSFT. The system is required to deliver additional activity above the levels set out in the annual planning guidance, along with an enhanced programme of transformation. For the SNEE system these targets are set at 100% of the 2019/20 baseline activity by July and 120% by September. This recognises the challenges which will be faced by WSFT over the coming year in relation to the significant estates work programme.

There are three broad elements to the plan – capacity, transformation and sustainability. Each of the underpinning elements is in line with the expectations of the annual planning guidance.

Accelerator sites are expected to deliver above baseline planning guidance requirements and share learning with other trusts. The programme offers an opportunity to develop a rapid increase in elective capacity, and thus reduce the longest elective care waits, and to address long-standing access barriers, such as transformation of the outpatient service model.

The programme will be led jointly by the CCG, WSFT and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) with named senior responsible officers (SROs) for each workstream.

Capacity

Priority one focuses on critical capacity increase and productivity initiatives to deliver additional activity and support a reduction in waiting times for elective patients.

The delivery model has been built via a combination of standalone service initiatives and specific capacity increases and critically focuses on joint working across all three trusts in the SNEE ICS to reduce inequities in waiting times. These can be summarised as follows:

- an increase in theatre capacity via the procurement of a vanguard theatre (located at Ipswich Hospital) but to be used to deliver WSFT activity in the initial phase
- maximising independent sector capacity across the region
- recommissioning of a mothballed theatre at WSFT
- additional CT, MRI and endoscopy capacity to improve diagnostic waiting times
- day case and theatre reprofiling – this includes productivity initiatives and rescheduling main theatre activity in the day surgery unit
- increased weekend working in both main theatres and day surgery
- review of infection prevention and control guidance to facilitate increased throughput
- high throughput focused activity in specific services such as super surge weekends.

Transformation

Priority two focuses on transformation and the delivery of workstreams that transform services to meet the needs of service users, both now and in the future. In this way the programme is supporting both elective recovery (now) and service delivery post pandemic (future).

The transformation programmes include the following initiatives:

- a comprehensive outpatient development programme, which includes work on digital transformation, advice and guidance, patient initiated follow up (PIFU) amongst others
- nationally identified pathways which can be considered high volume, low complexity (HVLC) (29 designated pathways in the following specialties - cardiology, trauma and orthopaedics /musculoskeletal, ophthalmology, gynaecology, ear, nose and throat (ENT), general surgery and urology)
- identified opportunities to deliver joint management of waiting lists
- patient choice and transfer of clinical care between providers
- reduced long waits, particularly of those cohorts of patients waiting the longest (52+ weeks)
- clinical validation to ensure consistent clinical prioritisation across all points of delivery
- improved patient optimisation in primary and secondary care with a focus on health inequalities
- productivity opportunities via review of available benchmarking data, such as model hospital and getting it right first time (GIRFT)
- workforce, including recruitment programmes and development of new and expanded roles.

Sustainability

Priority three is sustainability and the creation of a framework in which success is achieved and informs future service configuration. This includes formalised success metrics, reporting, benchmarking and performance management. There are clear synergies between the elective accelerator programme and the future system work and both teams are keen to take a joined up and collaborative approach. It is important that we avoid duplication and engage our clinical teams once collectively, rather than separately or in an uncoordinated way.

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.

As we emerged from the first wave of COVID-19 we commissioned a piece of work from ReThink partners to engage with our community teams about their experiences of being part of WSFT. This work has resulted in a major organisational restructure within community heath and social care to better enable the vision of integrated working. A new joint director post between adult health and

social care has been created with the aim of strengthening joint working and reducing duplication and inefficiencies. This post will be supported by alliance delivery managers for health, social care, primary care and mental health and service transformation.

2020-21 saw the successful transition of our community teams onto the West Suffolk IT infrastructure. This long-awaited move has provided the platform for greater digital opportunities for the community teams as we work to develop parity with acute colleagues. Whilst there is still more to do, community teams are already seeing and feeling the benefits of this investment in new kit and infrastructure. We have implemented electronic staff rostering alongside a capacity and demand tool to enable us to plan our resources better to meet the needs of our communities. We are now working to deploy an electronic appointment/visit scheduling system to release clinical time to deliver patient care.

There has been significant focus on the development of pathway one discharges to support more people to continue to live in their own homes. This, along with the implementation of seven-day reactive services across the community, has enhanced the support available to patients to support admission avoidance and early discharge from hospital.

Urgent and emergency care

WSFT is one of 14 pilot sites currently undertaking field testing for new emergency care standards. Due to the impact of COVID-19, plans to roll out the pilot nationally were put on hold. However, it is anticipated that the national implementation will begin in a phased way later this year.

Our key area of work to support flow through ED and the hospital is a length of stay programme supported by Emergency Care Improvement Support Team (ECIST).

The programme has four workstreams all aimed at reducing length of stay and improving discharge processes across the Trust:

- frailty, including the creation of a new frailty unit at the front of the hospital
- discharge to assess, maximising the full potential of this service
- embracing risk, focused on implementation of right to reside guidance
- length of stay overall, focused on benchmarking and data analysis to identify opportunities.

New healthcare facility (Future System programme)

In September 2019, the Government announced its Health Infrastructure Plan, which aims to deliver a long-term programme of investment in health infrastructure, including funding for 40 new hospitals. The WSFT was named as one of the 40 new hospitals and has embarked on a journey to bring a new healthcare facility to fruition.

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

The Trust and its partners within the local integrated care system (ICS) and West Suffolk Alliance are at the beginning of a comprehensive and inclusive programme of work that will encourage input from the widest possible set of stakeholders.

At the end of 2020, we confirmed that the recently purchased Hardwick Manor had, following an extensive appraisal process, been selected as our preferred site for the new facility.

The main benefits of the Hardwick Manor site:

- owned by the Trust
- minimises disruption caused by relocation and allows us to retain existing, modern infrastructure such as the Drummond Education Centre and Quince House, ensuring the best use of public funds
- maintains close proximity to co-located partners such as St. Nicholas Hospice and mental health provider Norfolk and Suffolk NHS Foundation Trust.

Next steps
We are developing the clinical model to be deployed at the new facility and a detailed assessment of the environmental impact that building a new hospital on Hardwick Manor will have on flora, fauna, traffic, parking and residents. This work will inform outline hospital designs and an application for planning consent.

The programme is governed by a board that has drawn its membership from across the Suffolk and North East Essex ICS. This membership has collectively committed to making the new facility the most co-produced in the country – a tall ambition that confirms our commitment that it is designed by our people for our people.

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

Trust digital programme

The planned Trust digital programme for 2020/21, like so much of the Trust activity, was severely affected and impacted by COVID-19. However, the digital teams rose to the challenge this presented with focus and determination to support front line staff and services.

The major planned projects and programmes were put on hold and resources were refocused on a new set of emerging priorities:

- support for the newly created ‘Keeping in Touch’ service, to provide digital tools for patients to see and speak to their families and loved ones, was delivered at pace using mobile iPad carts
- purchase, configuration and delivery of in excess of 1,300 laptops to enable remote working, together with increased remote access capacity and resilience
- rapid acceleration of plans for roll out of Microsoft Teams to support the new demands of remote working and virtual engagement.

Across the wider system, plans for further connections to the Health Information Exchange (HIE), that delivers a shared care record across the Suffolk and North East Essex (SNEE) ICS, were accelerated in anticipation of transfer of patients to COVID-19 surge centres. The planned programme to join Mid and South Essex sustainability and transformation partnership into HIE was also expedited and the other SNEE acute hospitals connected.

The growth in HIE has further continued, with social care having access to HIE through connections to both Essex County Council and Suffolk County Council. Additional GP practices, community teams and hospices across the region were connected and we saw growth over the year, from around 15,000 views in April 2020 to over 80,000 views in March 2021, representing an increase of well over 400%. The significance of this growth and continued expansion has been reinforced by the national imperative of shared care records required by September 2021.

Two of the major projects that were put on hold were still able to be successfully completed at the end of the year, despite the demands of the second wave of COVID-19:

- **Community**
  We completed several projects as a result of significant investment in community digital infrastructure, including moving community staff onto Trust computers and connecting them to the Trust network and taking advantage of the Trust's internet-based telephony system. This also moved the storage of files and folders to a cloud-based platform using Microsoft's SharePoint product. The investment allows us to build on the idea of an 'anchor tenant model' across the Trust's estate where one organisation takes responsibility for the IT services on that site.

- **e-Care phase 4**
  Over the weekend of the 19 – 22 of March 2021, the Trust successfully went live with its 4th phase of Cerner Millennium (e-Care). This involved a huge change for the maternity and neonatal departments, with the implementation of Maternity and FetaLink modules for both inpatients and the community. This is a further step to moving to a fully digitised hospital.

  The Trust also successfully implemented warfarin prescribing and administration, scanning for safety and electronic medicines requesting – all of which offer significant safety benefits around medicines management. Phase 4 also included a major update to the drug catalogue.

  A key feature of the work was the close cooperation and involvement of the various clinical teams and the wider engagement with staff to reach the required safe training levels. The training was delivered using a variety of in-person, virtual and online methods and the implementation of a learning management system has commenced, which will further enhance the Trust's ability to manage and deliver online and virtual learning.

The ongoing work to migrate end point and server operating systems onto currently supported releases continues, delayed by the COVID-19 response. This, together with a wide range of related measures, is mandated by the requirement to ensure we are able meet the constant challenge of cyber security threats.

The digital team supported the move of Oakfield GP Surgery into the Newmarket Community Hospital by co-designing the IT infrastructure. This included the installation of a super-fast fibre connection into Newmarket Community Hospital to support the expansion of the hospital into a community hub for the Western Alliance. Closed system working was supported by relocating community teams into the council building at West Suffolk House and the team continued working closely with the Western Alliance as NHS technical lead for the Mildenhall Hub.

As well as the delivery of some of the major programmes of work the Trust has been able to implement some 243 e-Care change requests, many related to COVID-19, and this represents a continued focus on optimization initiatives that will further enhance usability and streamline workflows for clinical staff. In addition, standardised nursing handover tools have been implemented, e-Care has been extended to Glastonbury Court and the first interactive care pathway has been introduced.

Staff vaccination programme

The digital development and integration team was an integral part of the vaccination programme and was able to deliver a simple but engaging system that supported the emerging vaccination process with an emphasis on minimising the data entry required. This work will continue as the demand to support public vaccination develops and the requirement for booster vaccinations becomes clearer.

Looking forward

The Trust has been able to progress its digital ambitions whilst at the same time responding to the immediate COVID-19 challenge. The Trust continues to emphasise digital transformation as a tool to develop the organisation and bring enhanced workflows and efficiencies into operation.

The current governance structure, which follows the four pillars of digital delivery, is under review and new governance arrangements will be implemented during 2021/22. The Trust's digital strategy will

be restated in the early part of 2021/22, aligned with the overall Trust strategy and the ambitions of the Future System.

Procurement

The impact of the pandemic has changed the procurement landscape and, as such, supply chain routes, EU directives and procurement of goods is still not clear. The purchasing department is working with all the national teams to review how procurement will evolve over the coming twelve months. The areas of direction currently under review are:

- ensure the new procurement regulations and requirements by all public sector bodies are implemented in 2021
- resubmit level one of the Department of Health revised standards of procurement and work toward level two
- implement the new national contracts management system that achieves better visibility of contract spend and monitoring of key performance indicators, ensuring compliance and benefits realisation are being achieved
- reinstate the model hospital procurement metrics and spend comparison service tool.

Priorities for the Trust procurement over the coming twelve months are:

- support the directorates as we move back to business as usual
- achieve the Trust workplan which links with NHS England / Improvement and NHS supply chain
- ensure overall the Trust is achieving value for money by working in collaboration with other bodies, testing the market and benchmarking.

Agency rules

The two main clinical staff groups where agency staff are used are doctors and nurses. During 2020/21 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 2020/21, despite the huge increased demand on services during the pandemic, we have successfully reduced our reliance on agency, bringing down the usage by 25%. This has also had the effect of increasing the competition between agencies. The reduction in shifts put out to agencies has also improved our negotiating position for agencies to comply with capped 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.

A large part of the estate is more than 47 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 advising that parts of the structure could be affected by shear failure with very limited warning. The alert related to a significant proportion of the hospital which is constructed of reinforced aerated autoclaved concrete (RAAC) planks, which have structural properties.

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.

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:

- **Theatre 1** - the plan for 2021/22 includes recommissioning of theatre 1, which is currently used for storage and administration, back to a general theatre and to provide an alternative bed storage area

- **Emergency department** - a second phase of improvements within the emergency department provides additional capacity for rapid assessment of patients, aimed at improving the transfer of patients arriving by ambulance. The development includes space for up to eight patients (four trolley spaces and four chair spaces), two consulting rooms, a drug prep room, dirty utility, a WC and two store rooms

- **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 funding to support the Trust with the delivery of this aspect of the investment plan

  Key schemes planned for 2021/22 include:

  - completion of re-roofing programme
  - additional capacity (32 bed ward) to release capacity to facilitate the failsafe programme
  - installation of supporting mechanisms and ongoing surveillance

- **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 2021/22 include:

  - hot and cold water systems associated with legionella
  - main fire alarm system upgrade
  - site electrical infrastructure resilience
  - additional bulk medical oxygen storage (VIE)

- **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, the West Suffolk NHS Foundation Trust has the following sustainability mission statement located in our sustainable development management plan (SDMP):

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

The NHS is committed to tackling climate change by reducing emissions to 'net zero'. Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

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

(Delivering a 'Net Zero' National Health Service October 2020)

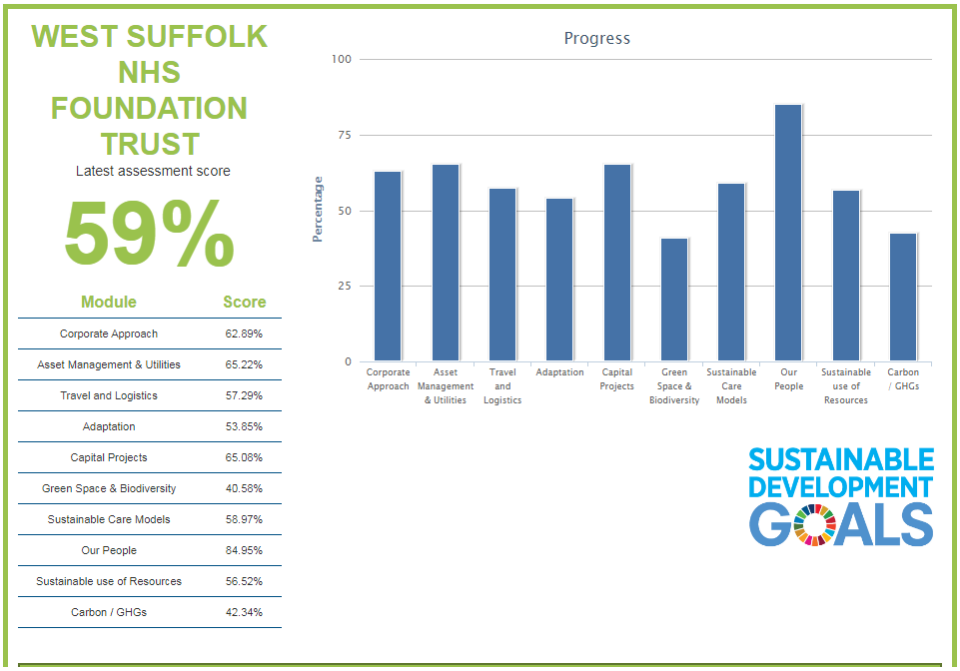
In order to embed sustainability within our business it is important to explain where sustainability features in our process and procedures. The Board-approved travel plan includes active travel approaches such as walking and cycling and is reviewed annually. The procurement sustainability policy provides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

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

In 2020 - 2021 the sustainable development action plan focused on NHS Service Contract 2020/21 commitments. However, the Trust response to the COVID-19 pandemic has meant that some

sustainability initiatives have been delayed or suspended, such as the wider introduction of plastic recycling across the Trust. These projects will be revisited when normal services resume.

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 SDGs:

Adaptation

Climate change brings new challenges to our business, both in relation to the healthcare estates and also to patient health. Examples in recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Board-approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change.

The Trust is very aware of its responsibilities to ensure all planning includes measures to address climate-induced hazards. The Trust's emergency plans for severe weather include such awareness, and the overarching command and control capability has a programme of training and testing.

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, The Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, working closely with the West Suffolk CCG and with wider stakeholders such as the ambulance service, independent care providers the voluntary community sector, employers, the education sector and business.

Energy

Resource		2016/17	2017/18	2018/19	2019/20	2020/21
Gas	Use (kWh)	22,915,910	25,103,388	24,605,975	26,394,446	27,222,128
	tCO_2e	4,789	5,322	5,217	5,596	5,656
Oil	Use (kWh)	2,823,162	1,075,600	0	0	0
	tCO_2e	895	351	0	0	0
Electricity	Use (kWh)	3,699,138	2,808,885	4,594,967	5,578,407	5,217,833
	tCO_2e	1,912	1,252	2,048	1,946	1,503
Total energy CO_2e		7,596	6,925	7,265	7,542	7,159
Total energy spend		£1,073,831	£1,047,805	£996,002	£1,040,358	£1,159,217

Source of data 2017 – 2020 - ERIC returns to the Information Centre and BEIS carbon factor 2020/21

Photovoltaic panels – energy generation

Energy **output** PV panels (kWh)	2018/19	2019/2020	2020/2021
Quince House	6,381	10,741	10,891
Accommodation (Beeton, Bloomfield and Clarke)	-	23,693	27,036

2020-2021 data correct at 22/4/21

The Trust joined the Feed-in-Tariff (FIT) scheme and receives an income per kWh generated from the photovoltaic (PV) panels placed on Beeton, Bloomfield and Clarke House accommodation.

During 2020-2021 this scheme has generated an income of £1,081.

Combined heat and power unit

	2016/17	2017/18	2018/19	2019/20	2020/21
Fossil energy **input** to the CHP system (kWh)	16,998,484	15,942,272	14,514,629	17,176,672	15,971,654
Electrical energy **output** of CHP system (kWh)	5,656,174	5,262,992	5,144,790	5,501,661	5,128,958
Thermal energy **output** of CHP system (kWh)	6,448,000	2,700,000*	*4,160030	7,272,380	7,479,210

2020 - 2021 data correct at 22/4/21

Paper

Paper		2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Volume used	Tonnes	48	45	44	42	38
Carbon emissions	tCO_2e	46	43	41	40	36

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

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

Business travel – Agenda for Change and junior doctors

	Mileage	tCO2e*
2019-2020	574,593	160
2020-2021	402,668	111

(*BEIS carbon factor 2020-2021 cars by size 0.1714/km)

WEEE waste

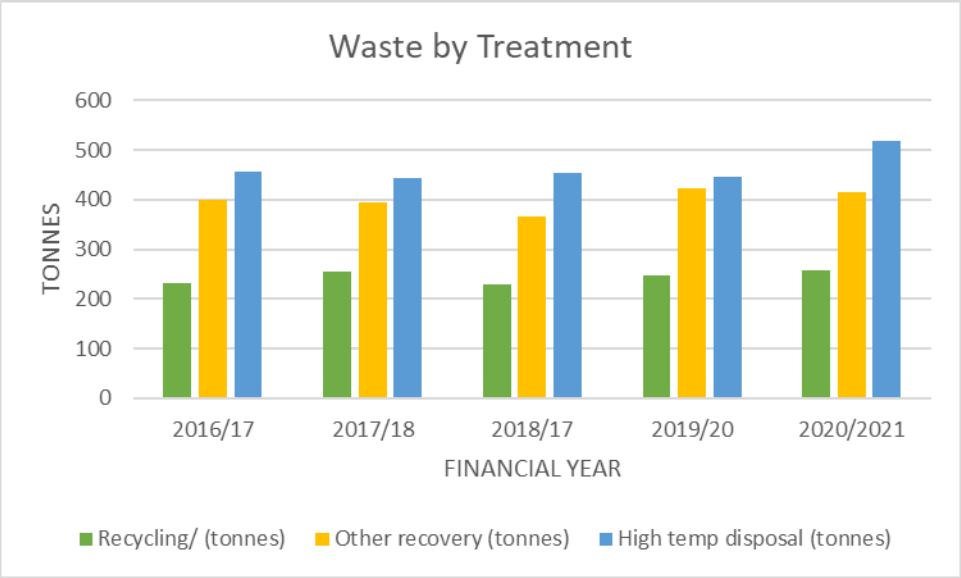
Through our contractor, CDL, the Trust sent 6.3 tonnes of waste electronic and electrical equipment (WEEE) on for reuse out of a total of 20.8 tonnes collected. The Trust Waste Management Policy outlines our commitment to applying the principles set out in the waste hierarchy.

Total waste (clinical and non clinical):

Waste		2016/17	2017/18	2018/17	2019/20	2020/2021
Recycling/ re-use	(tonnes)	231.96	254.14	228.28	246.1	257.94
	tCO_2e	4.87	5.53	4.88	5.36	5.49
Other recovery	(tonnes)	398.76	393.94	364.94	423.74	414.26
	tCO_2e	8.37	8.57	7.81	9.22	8.82
High temp disposal	(tonnes)	455.06	444.10	452.76	445.54	517.71
	tCO_2e	100.11	97.70	99.7	98.02	113.90
Landfill	(tonnes)	0.00	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00	0.00
Total waste (tonnes)		1,085.78	1,092.18	1,045.98	1,115.38	1,189.65
% Recycled or re-used		**21%**	**23%**	**22%**	**22%**	**22%**
Total waste tCO_2e		**113.36**	**111.80**	**112.39**	**112.60**	**128.22**

Data source – quarterly waste returns, data correct at 22/04/2021, BEIS carbon factors 2020-2021

Data source – quarterly waste returns, data correct at 22/04/21



Data source – quarterly waste returns, data correct at 22/4/2021

Recycling target
The Trust is committed to applying the waste hierarchy in how we approach waste, as outlined in the waste policy. Where reducing or reusing waste is not possible, we aim to recycle such waste. We have set an ambitious target of 30% of our total waste to be recycled by 2026. In 2020-2021 22% of total waste was recycled.

Plastic waste
In 2020/21, 11.28 tonnes of plastic bottles were recycled, an increase of 5.76 tonnes on the previous year. This is due, in part, to a further roll out of plastic bottle collection points in the Trust, with additional collection points planned for 2021/22.

Glass recycling at the day surgery unit
We have recently launched a glass recycling service for our day surgery unit through our waste partnership with West Suffolk Council. The opportunity to introduce this stream was driven by the department, which generates a significant amount of glass waste on a weekly basis. This stream will divert waste from the general waste compactor whilst increasing waste recycling at the Trust.

Through our sharps collection partner Sharpsmart, we have introduced a metal recycling stream for day surgery and main theatres. This stream diverts waste from the yellow-lidded sharps stream into a green-lidded bin, providing the opportunity to separate recyclable items such as scissors, metal hip joints, ortho hammers and wire.

Food waste trial
2020-2021 saw the roll out of the Trust's food waste stream, which diverted 33 tonnes of food waste originating from the kitchen, from energy from waste facilities to anaerobic digestion. Not only has this led to environmental benefits, but we have also saved £1,771 on our waste costs.

Finite resource use – water

Water		2016/17	2017/18	2018/19	2019/20 *	2020/2021
Mains water	m^3	71,300	96,682	121,030	111,001	133,409
	tCO_2e	65	88	110	101	140.34
Water and sewage spend	£	£148,800	£205,547	£263,086	£189,056	£320,387

Source of data 2017 – 2020 - ERIC returns to the Information Centre.
* Note: 2019/20 data is based on the available 10 months information (Apr 2019 – Jan 2020)

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

For example:

- The Trust successfully applied for the Low Carbon Skills Fund (LCSF), a fund set up to support the Public Sector Decarbonisation Fund (PSDF). Through the LCSF a feasibility study was carried out into the decarbonisation of Newmarket Community Hospital. This identified energy efficiency measures to reduce the heat demand of the building and identified the opportunity for the installation of an air source heat pump (ASHP). The study also looked into solar PV and LED lighting and will serve to inform future projects at the hospital with a view to reduce the carbon intensity of the services we provide.

- The Trust has completed phase 2 of a project to install LED lighting across the main hospital and is committed to installing LED lighting in new buildings and projects in the future. Through embedded technology and the greater efficiency of our LED lighting, we have improved the quality of lighting across the Trust recognising the benefit for patient care. Since the project's inception in December 2019 we have saved 230MWh of electricity and made a saving of £28,257.21 on our electricity bills.

In addition, there have been some green benefits resulting from the new ways of working that have been developed or accelerated as part of the COVID response. More remote clinic appointments have been offered saving journeys to site, and staff have been encouraged to work from home where possible, resulting in CO2 savings on the staff commute. The use of Microsoft Teams in place of travelling to face to face meetings has also had an impact on business mileage.

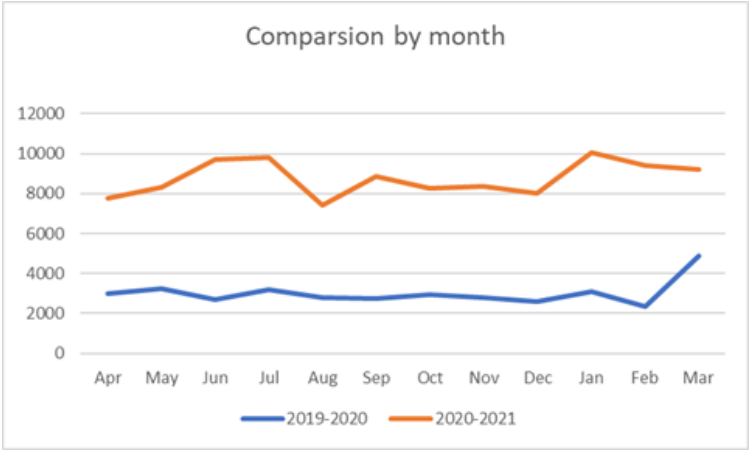
Staff travel
A group of colleagues in estates and facilities developed a rota of staff working from home when possible and working on site to ensure that office areas remained COVID-19 secure and expected service levels and responses were maintained. From April to December 2020 the group spent a combined total of 1,773 days working from home resulting in 59,288 miles being saved in the daily commute to work. Based on average CO2 emissions per car per mile (BEIS carbon factor car (by size) 2020-2021), approximately 16.3 tonnes of CO2e emissions were avoided.

Small screen therapy
Specialist teams in our integrated community paediatric service have done all they can to use the technologies on offer to maintain the services they provide for children and young people across Suffolk. At the start of the pandemic, paediatric speech and language colleagues kept in touch with

children and their families by phone, but now they mostly use Microsoft Teams. In the future it is likely that the team will provide a blended offer, with a mix of virtual and face to face consultations.

Remote appointments

month	2019-2020	2020-2021
Apr	2997	7777
May	3238	8295
Jun	2683	9720
Jul	3183	9825
Aug	2785	7417
Sep	2753	8856
Oct	2922	8241
Nov	2785	8383
Dec	2600	7991
Jan	3072	10033
Feb	2339	9390
Mar	4885	9227



The number of remote appointments for patients almost trebled in the last year, from 36,242 in 2019 - 2020 to 105,155 in 2020 – 2021, reducing the number of visits to the hospital site and avoiding C02e emissions from patient travel. This data excludes any appointments linked with COVID-19.

Reusable coffee cups

As part of the Trust's response to staff wellbeing during the pandemic, free hot drinks have been made available to all staff, causing an increase in the number of single use cups purchased. Waste data for 2020 shows that 480,000 single use cups were used at a cost of £25,910. In addition, this generated 7.68 tonnes of waste and 29 tonnes of CO_2e, with a disposal cost of £1,035.

In March 2021 the My WiSH Charity, working with the catering department and the estates energy and waste officer, distributed 5,000 reusable coffee cups - one for each member of Trust staff. Single use coffee cups were removed from drinks machines around the hospital, but are still available in the staff restaurant. The impact on the volume of single use coffee cups will be monitored throughout 2021.

2021 - 2022

Due to the impact of COVID, the update and review of the Sustainable Development Management Plan was delayed. This will be carried out in 2021-2022 and will become the Green Plan, and national guidance will inform the plan. The associated action plan will focus on the areas outlined in section 6 of the NHS contract and updated service conditions and the targets set out in Delivering a 'Net Zero' National Health Service (2020), including:

- proposals to meet reductions in business and fleet air pollutant emissions (finance/facilities/purchasing)
- a review of business travel reimbursement for domestic flights within England, Scotland and Wales (finance/facilities/HR)
- sign-up to the plastics pledge and continue to work with suppliers to identify viable alternatives to single use plastic catering items (facilities/purchasing)
- where possible extend to wards (straws, plastic cups, cotton buds etc.) (purchasing/clinical)
- increasing the percentage of renewable electricity in the fuel mix (estates)
- reducing the overall carbon impact of all inhalers dispensed at pharmacy (pharmacy, clinical)
- review the opportunity to reduce the proportion of desflurane to sevoflurane used in surgery to less than 20% by volume (pharmacy, clinical)
- assess the potential to reduce unnecessary emissions of nitrous oxide to the atmosphere (anaesthetics, estates, capital projects)
- Replacing lighting with LED alternatives – including Newmarket Community Hospital.

Equality of service delivery to different groups

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

Five of our nine equality, diversity and inclusion objectives for 2019 - 2021 relate to our patients, service users and carers. Action to support us achieve our objectives include:

- engaging with staff, patients and service users to ensure the chapel at West Suffolk Hospital is an inclusive space for all
- promoting the take-up of screening by people who are trans e.g. cervical screening
- installing Browsealoud on the Trust website. This allows the website to be converted into different accessible formats as well as translating it into other languages. The software can also convert the format of PDF documents and fully translate them into other languages
- working with our patient administration system provider to enable us to record the preferred gender identity of all patients
- All patients and visitors to the Trust have access to a detailed access guide that lets them know what access will be like when they visit the West Suffolk Hospital site via a link on our website to AccessAble.

The link to our inclusion strategy and action plan can be found here.

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[1]
Mary Allan[1]
Gordon Baynes[2][3]
Florence Bevan
Derek Blackman[2]
June Carpenter [1]
Justine Corney[1]
Allen Drain[4]
Jayne Gilbert[1]
Robin Howe
Mark Krempel[2]
Ben Lord[2]
Roy Mawford[2]
Gordon McKay[1]
Barry Moult [1]
Jayne Neal
Adrian Osborne
Joe Pajak
Margaret Rutter[2]
Jane Skinner
Liz Steele (lead governor)
Clive Wilson[2]

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

Peta Cook[1]
Rachel Darrah[2]
Javed Imam[1]
Sarah Judge[2]
Amanda Keighley
Sarah-Jane Relf[2]
Vinod Shenoy[1]
Martin Wood

Partner governors – nominated by partner organisations of WSFT

Councillor Carol Bull[2]	West Suffolk Council also representing Mid-Suffolk District Council and Babergh District Council
Judy Cory[1]	Friends of West Suffolk Hospital
Dr Mark Gurnell[1]	University of Cambridge
Dr Andrew Hassan	West Suffolk Clinical Commissioning Group
Councillor Rebecca Hopfensperger	Suffolk County Council
Councillor Sara Mildmay-White[1]	West Suffolk Council also representing Mid-Suffolk District Council and Babergh District Council
Laraine Moody	West Suffolk College also representing University Campus Suffolk
Dr Thomas Pulimood[2]	University of Cambridge
Sarah Steele[2]	Friends of West Suffolk Hospital
Vacant (2nd representative)	West Suffolk Clinical Commissioning Group

[1] Governor until elections November 2020
[2] New governor elected/nominated November 2020
[3] Resigned from Council of Governors February 2021
[4] Appointed to Council of Governors March 2021

Governor attendance at council of governors' meetings 2020/21

There were six formal meetings of the council of governors: 6 May 2020, 7 July 2020 (held in private); 11 August 2020; 22 September 2020 (Annual Members Meeting); 11 November 2020; 11 February 2021. In line with social distancing requirements all formal and informal meetings, training and briefing sessions have taken place virtually during the COVID-19 response. The following governors were in attendance:

Name	Title	Attendance (out of six meetings)
Peter Alder[1]	Public governor	5 (of 5)
Mary Allan[1]	Public governor	3 (of 5)
Gordon Baynes[2][3]	Public governor	1 (of 1)
Florence Bevan	Public governor	6
Derel Blackman[2]	Public governor	1 (of 1)
Carol Bull[2]	Partner governor	1 (of 1)
June Carpenter [1]	Public governor	4 (of 5)
Justine Corney[1]	Public governor	3 (of 5)
Peta Cook[1]	Staff governor	5 (of 5)
Judy Cory[1]	Partner governor	5 (of 5)
Rachel Darrah[2]	Staff governor	1 (of 1)
Allen Drain[4]	Public governor	0 (of 0)
Jayne Gilbert[1]	Public governor	5 (of 5)
Mark Gurnell[1]	Partner governor	3 (of 5)
Andrew Hassan	Partner governor	6
Rebecca Hopfensperger	Partner governor	5
Robin Howe	Partner governor	6
Javed Imam[1]	Staff governor	1 (of 5)
Sarah Judge[2]	Staff governor	1 (of 1)
Amanda Keighley	Staff governor	5
Mark Krempel[2]	Public governor	1 (of 1)
Ben Lord[2]	Public governor	1 (of 1)
Roy Mawford[2]	Public governor	1 (of 1)

Name	Title	Attendance (out of six meetings)
Gordon McKay[1]	Public governor	5 (of 5)
Sara Mildmay-White[1]	Partner governor	4 (of 5)
Laraine Moody	Partner governor	3
Barry Moult [1]	Public governor	4 (of 5)
Jayne Neal	Public governor	5
Adrian Osborne	Public governor	4
Joe Pajak	Public governor	6
Thomas Pulimood[2]	Partner governor	1 (of 1)
Sarah-Jane Relf[2]	Staff governor	1 (of 1)
Margaret Rutter[2]	Public governor	0 (of 1)
Vinod Shenoy[1]	Staff governor	1 (of 5)
Jane Skinner	Public governor	6
Liz Steele (lead governor)	Staff governor	6
Sarah Steele[2]	Partner governor	1 (of 1)
Clive Wilson[2]	Staff governor	1 (of 1)
Martin Wood	Staff governor	6

[1] Governor until elections November 2020
[2] New governor elected/nominated November 2020
[3] Resigned from Council of Governors February 2021
[4] Appointed to Council of Governors March 2021

In attendance at these meetings were: Sheila Childerhouse, chair (6); Dr Richard Davies, non-executive director (4); Craig Black, executive director of resources (2); Dr Stephen Dunn, chief executive (4); Angus Eaton, non-executive director (5); Dr Nick Jenkins, executive medical director (1); Rosemary Mason, associate non-executive director - appointed 24 August 2020 (3); Gary Norgate, non-executive director – resigned 31 May 2020 (1); Louisa Pepper, non-executive director (5); Jeremy Over, executive director of workforce and communications (2); Rowan Procter, executive chef nurse – resigned 31 May 2020 (2); Alan Rose, non-executive director (5); David Wilkes, non-executive director - appointed 31 July 2020 (4); Susan Wilkinson, executive chief nurse - appointed June 2020 as interim and December 2020 in substantive role (2).

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 an understanding of the performance of the Board, particularly from a quality and finance perspective, and provides an insight into the role and performance of the non-executive directors (NEDs).

The NEDs present a summary of the finance report and the quality and performance report at the council of governors meetings. When required they also present reports on any other areas they lead on.

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

A joint council of governors and Board workshop scheduled for April 2020 to review the Trust's strategy and operational plan was cancelled due to COVID-19. A joint board and governor briefing on the new health facility took place in October 2020 and two further joint board and governor briefings were held in April 2021 and May 2021. A training session for governors and non-executive directors took place in March 2021.

The lead governor has continued to arrange informal meetings of governors and NEDs which has been beneficial in developing good working relationships. Informal, virtual "coffee" meetings have taken place with small groups of governors and non-executive directors to enable them to get to know one another better.

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

To support governors in engaging with staff, patients and the public they have previously taken part in activities including quality and environmental walkabouts, area observations and engagement sessions in the Courtyard Café. In line with social distancing requirements these activities have been paused during the COVID-19 response, however governors have engaged with staff through virtual meetings, including the regular all staff briefing.

The engagement committee, which is a sub-committee of the council of governors, meets quarterly. Governors provide feedback on key issues 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:

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

2.1.5 Membership

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

Public membership

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

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

Babergh:	All wards
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham

Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid-Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
Forest Heath:	All wards
Ipswich	All wards
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	All wards
South Norfolk:	Bressingham and Burston, Diss and Roydon
St Edmundsbury:	All wards
Suffolk Coastal	All wards
Waveney	All wards

In April 2021 the public membership area was extended to include the rest of Norfolk, Cambridgeshire and Essex (all wards not mentioned above) as part of second, separate public constituency.

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 2021 there were 6,251 public members and 5,826 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 recruitment initiatives. As well as recruiting new members this provides valuable feedback from patients and the public on their experiences and views of WSFT. In line with social distancing requirements these activities have been paused during the COVID-19 response.

The council of governors' engagement committee meets regularly to review the membership numbers and the targets set in the membership strategy to ensure that it is representative. It also considers ways of increasing membership in areas where numbers are low. The chair of this committee gives a

report to the quarterly council of governors meeting. Performance against the agreed targets remains good.

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

Criteria	Current March 2021	Target (March 2021)
1. Achievement of the recruitment target: a. total number of public members b. staff opting out of membership	**6,251** **<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)	**1,240** **20%**[1]	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**[2] **295 (2019)**	3[3] 400[2 and 3] 200

[1] Figure as at March 2020 (paused due to COVID-19)
[2] Includes people attending annual members' meeting – figure as at March 2020 (paused due to COVID-19)
[3] Figures have been adjusted due to COVID-19

During the past year the Trust has paused its membership interest events on services provided by WSFT. The annual members meeting was held virtually via YouTube.

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 2020 the nominations committee received an update on the recruitment process for a NED and associate NED which had been agreed in February 2020. Successful appointments for both positions were subsequently made and approved at a closed session of the council of governors in July 2020. At this meeting the committee reviewed the feedback from the appraisals of the NEDs and key messages that would be fed back to each individual. The committee also agreed to recommend to the council of governors that the chair and a NED whose first terms of office would end in December 2020 should be offered a further three-year term of office. This recommendation was approved by the council of governors in August 2020.

In February 2021 the committee received an update on the recruitment process for a NED position which would become vacant at the end of May 2021. A successful appointment was subsequently made and approved at a closed session of the council of governors in April 2021. The committee also agreed to recommend to the council of governors that a NED whose first term of office would end in August 2021 should be offered a further three-year term of office. This recommendation was approved by the council of governors in February 2021. At this meeting the committee reviewed the NED appraisal process and agreed the timetable for 2020. It was also agreed to defer consideration of NED and chair remuneration until national guidance was available.

Attendance at nominations committee meetings 2020/21

Name	Title	Attendance (out of two)
Sheila Childerhouse (chair)	Chair	2
Carol Bull[2]	Partner governor	1 (of 1)
Justine Corney[1]	Public governor	1 (of 1)
Roy Mawford[2]	Public governor	1 (of 1)
Sara Mildmay-White[1]	Partner governor	1 (of 1)
Barry Moult[1]	Public governor	1 (of 1)
Joe Pajak[2]	Public governor	1 (of 1)
Jane Skinner[1][2]	Public governor	2
Liz Steele [1][2]	Public governor	2
Martin Wood[1][2]	Staff governor	1 (of 2)

Meeting dates: 25 June 2020; 17 February 2021

[1] Committee member until governor elections November 2020
[2] Committee member following governor elections November 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: 1 January 2018 until 31 December 2020; reappointed 1 January 2021 until 31 December 2023)

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 integrated care system (ICS) 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: 1 March 2017 until 28 February 2020; reappointed 1 March 2020 until 28 February 2023)

Areas of special interest/responsibility: senior independent NED; chair of the insight committee (from May 2021); Trust wellbeing guardian, Board neonatal and maternity safety champion, member of the Future Systems programme board, remuneration committee, audit committee, and revalidation support group; NED link to medical director; and chair of learning from deaths group.

Richard was appointed to the Board through Cambridge University; he is a general practitioner and worked from 2004 in a variety of roles within the Cambridge University School of Clinical Medicine; including director of GP studies, and from 2013 until 2020 as a sub-dean in the Clinical School, with a particular responsibility for student welfare. He retired from clinical practice and from his formal university roles in August 2020. He continues to work as a clinical advisor to the university COVID helpdesk and as a vaccinator.

Independent director – yes (see Note 1)

Mr Angus Eaton - NED
(Appointed: 1 January 2018 until 31 December 2020; reappointed 1 January 2021 until 31 December 2023 – standing down with effect from 31 May 2021)

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 Hastings Group. His previous experience is across the legal, insurance and fund management sectors in various roles, including managing director (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 of Aviva UK commercial general insurance business; chief risk officer, Aviva UK and Ireland general insurance business; Aviva Group regulatory and operational risk director and group legal director.

Angus is also a NED of the Motor Insurance Bureau.

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

Angus stepped down from his role as NED at the end of May. Christopher Lawrence was appointed to the vacancy, including chair of the audit committee.

Mr Gary Norgate – NED and senior independent director (until 31 May 2020)
(Appointed: 1 September 2013 until 31 August 2016; reappointed 1 September 2016 until 31 August 2019; reappointed 1 September 2019 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: 1 September 2018 until 31 August 2021; reappointed until 31 August 2024)

Areas of special interest/responsibility: Member of the audit committee, remuneration committee, chair of scrutiny committee, chair of ethics committee, and second lead for improvement 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. 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: 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.

Chair of the involvement committee (from May 2021); member of the audit committee, scrutiny committee, remuneration committee and charitable funds committee; NED lead for patient experience, end of life care and adult safeguarding.

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)

Mr David Wilkes – NED
(Appointed 31 July 2020 until 30 July 2023)

Areas of special interest/responsibility: chair of improvement committee (from May 2021) and charitable funds committee; member of scrutiny committee, remuneration committee and audit committee.

David has a background in the malting business and is currently a non-executive director of Pauls Malt Ltd (Boortmalt); having been deputy group CEO and chief commercial officer for Boortmalt. Previous to this he held board and senior level positions with Greencore Malt and Pauls Malt Ltd.

David has previously been a trustee and director of Age UK, Suffolk, vice chair and trustee of St Elizabeth Hospice, Ipswich and chair and trustee of East Anglia's Children's Hospices (EACH).

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

Mrs Rosemary Mason – Associate NED
(Appointed 24 August 2020 until 23 August 2023)

Areas of special interest/responsibility: member of audit committee, member of scrutiny committee, involvement committee, link NED for the West Suffolk Alliance and link NED on WSH structural issues.

Rosemary has over 25 years' experience in senior leadership roles in the global manufacturing sector: including nine years in various leadership roles for Huhtamki Oyj, including MD Western Europe and the UK, and 15 years in leadership roles, including chief operating officer for Betts/Courtaulds plc.

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. He resigned as a non-executive director on 31 May 2020.

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

Helen has 36 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 The Ipswich Hospital NHS Trust.

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

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 and honorary commander of RAF Lakenheath.

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. Most recently he has led the Trust's vaccination programme.

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.

Nick stepped down from his role as medical director at the end of May 2021. Deputy medical director Dr Paul Molyneux took over in the interim while the recruitment process for a replacement takes place.

Mrs Rowan Procter – executive chief nurse (until 1 June 2020)

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 and Care Quality Commission (CQC) lead for the Trust.

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*

Areas of responsibility: oversees all aspects of the Trust's workforce strategy and practice, including: organisational development; leadership and management development; education and training; welfare and staff wellbeing including occupational health; equality, diversity and inclusion; pay and reward; employee relations, recruitment and workforce planning. He is also 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 over 20 years' experience in people management and development roles in the NHS, having started out as a training officer in his home town of Hereford. 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.

Mrs Susan Wilkinson – executive chief nurse (from June 2020)

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. Sue is also the director of infection prevention and control; CQC lead for the Trust.

Sue was appointed as interim executive chief nurse in June 2020 and was successful in her substantive appointment in December 2020

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

divisional head of nursing for surgery, and assistant director of nursing. Sue is a registered nurse and has a BSc in health care studies, including advanced practice and non-medical prescribing and an MSc in health care management and leadership.

* 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 in her capacity as the director of integration and partnerships.

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 2020/21

Name	Title	Attendance (out of 10)
Helen Beck	Chief operating officer	10
Craig Black	Executive director of resources	9
Sheila Childerhouse	Chair	10
Richard Davies	Non-executive director	9

Stephen Dunn	Chief executive	10
Angus Eaton	Non-executive director	10
Nick Jenkins	Executive medical director	10
Rosemary Mason[(a)]	Associate non-executive director	6(of 6)
Gary Norgate[(b)]	Non-executive director	2(of 2)
Jeremy Over	Executive director of workforce and communications	10
Louisa Pepper	Non-executive director	10
Rowan Procter[(c)]	Executive chief nurse	2(of 2)
Alan Rose	Non-executive director	10
David Wilkes[(d)]	Non-executive director	7 (of 7)
Susan Wilkinson[(e)]	Executive chief curse	8(of 8)

(a) Rosemary Mason was appointed as associate non-executive director from 24 August 2020
(b) Gary Norgate resigned as non-executive director on 31 May 2020
(c) Rowan Procter resigned as executive chief nurse on 29 June 2020
(d) David Wilkes was appointed as non-executive director on 31 July 2020
(e) Susan Wilkinson was appointed as interim executive chief nurse in June 2020 and was appointed to the substantive role in December 2020

Meeting dates
24 April 2020, 29 May 2020, 26 June 2020, 31 July 2020, 2 October 2020, 6 November 2020, 4 December 2020, 29 January 2021, 26 February 2021, 26 March 2021

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

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 this 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 auditor, 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 2020/21 then made a direct award for 2021/22. The cost of statutory services for the 2020/21 financial year was £74,000 (2019/20: £54,000).

Non-audit work may be performed by the external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For all such assignments the audit committee will be advised, which will ensure that objectivity and independence is safeguarded. No such work was undertaken in 2020/21.

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	5
Richard Davies	Non-executive director	5
Angus Eaton	Non-executive director (audit committee chair)	5
Rosemary Mason[1]	Associate non-executive director	2(of 2)
Gary Norgate[2]	Non-executive director	1(of 1)
Louisa Pepper	Non-executive director	5
Alan Rose	Non-executive director	5

David Wilkes[3]	Non-executive director	2(of 2)

Meeting dates: 24 April 2020, 19 June 2020, 31 July 2020, 6 November 2020 and 29 January 2021

[1] Rosemary Mason was appointed as associate non-executive director from 24 August 2020
[2] Gary Norgate resigned as non-executive director on 31 May 2020
[3] David Wilkes was appointed as non-executive director on 31 July 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 2020/21 the Board engaged with senior leaders to review its subcommittee structure and assurance arrangements for quality, safety, engagement and improvement. Following discussion with NHS England and Improvement a well-led developmental review will be used to evaluate the implementation and effectiveness of the new structure. Further details of the structure are provided in the annual governance statement (section 2.6).

2.2.8 Details of consultation

Church Field Road
In November 2018, the Trust consulted the local community on our proposals to develop the Church Field Road site in Sudbury. We reviewed all the comments that were made and in response 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 to introduce some bungalows and smaller homes. The two entrances to 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.

The planning application was submitted on 12 March 2020, with the submission documents adjusted to show where consideration had been given to comments made during the consultation. The number of homes was reduced to 190.

The statutory planning application consultation process was undertaken between 14 April and 5 May 2021. As a result of feedback received the application was revised with the homes reduced to 166 units, with up to 60 beds in the care home. This information was submitted to Babergh District Council planning authority on 10 March 2021, and the Trust awaits comments on the revised documentation.

West Suffolk Hospital
On 18 August 2020 planning permission was sought for a single storey extension to the west of the main hospital building to provide a decant ward (an empty ward to allow patients to be accommodated while work is carried out in another clinical area) with link corridor access and pathway to the existing hospital. This was to facilitate remediation works required for the original hospital building as a result

of its age and will allow for essential maintenance works to be undertaken. The statutory planning consultation period for this scheme ran from 26 November to 17 December 2020.

Public engagement has continued throughout the year with some necessary pauses in project work during COVID-19 restrictions. The Trust's patient and public engagement group have, however, made progress on the development of their duties, including:

- establishing four dedicated patient representatives for the Future System programme
- involvement in the development of the Future System programme, with representation on the community engagement group
- recruitment of additional members with a diverse range of experiences and backgrounds
- participating in a national event hosted by NHS England and Improvement - 'Patient Experience for Improvement'
- formal training on:
    - working with people with dementia
    - mental health needs and the Mental Capacity Act
    - health literacy
    - co-production
- establishing links to local community networks and groups
- networking with other patient groups across the region.

The group has continued to connect and engage throughout the year, focusing on developing its knowledge and understanding while face-to-face engagement with patients and the public has been challenging.

Future system programme

A new facility is to be built for the people of west Suffolk by the people of west Suffolk involving members of the community in meaningful engagement, co-producing the building design and clinical model with members of staff and the wider public. It means everyone - staff, patients and system partners – have an equal stake in developing the new healthcare centre and its services.
The result will be a building design and clinical model that is fit for the needs of our population now and in the future for all generations.

The engagement activity has been split into those associated with the estate and work relating to the clinical design.

Estate

Communication and engagement on the options of where to locate a future health and care facility has taken place in phases, this includes the acquisition of a potential site at Hardwick Manor and the announcement of the preferred site.

Acquisition of Hardwick Manor
The Trust was given the opportunity to purchase one of its shortlisted sites. This purchase enabled the Trust to secure the site safeguarding it as a possible location whilst evaluations continued on all shortlisted sites.

Having received advanced funding for the pre-emptive acquisition of Hardwick Manor, the Trust reached out to its stakeholders, staff and patients in the following ways:

- local and county councils – council colleagues were invited to become integral members of the estates technical team so they could be engaged in every part of the acquisition and its communication
- programme board presentation – programme board members were informed of the potential acquisition and completion
- NHS England and Improvement and the Department of Health and Social Care – representatives were heavily engaged and were, as part of the funding conditions, kept informed throughout the acquisition

- staff and governors – staff received a cascade of information utilising the channels established to ensure effective COVID-19 restriction compliant briefings, and
- governors were informed of the acquisition at a dedicated presentation for local residents – 400 letters were delivered in the immediate vicinity of the Hardwick Manor site. The families of the 40 closest houses were invited to video and audio engagement events and encouraged to raise concerns and thoughts. Two families then requested meetings to discuss the preservation of privacy, which were organised
- wider public – a press release was issued following staff, governor and neighbour communications.

Feedback from this decision was broadly positive with clear appreciation signalled by staff, stakeholders and neighbours for the level of engagement.

Selecting and announcing a preferred site
In 2008 St. Edmundsbury Borough Council prepared its Local Development Framework (LDF) and published its 'Core Strategy Preferred Options and Strategic Sites Options and Issues' which provided a broad vision and direction for development to 2031.The plan recognised that the Trust needed a new acute hospital to accommodate housing and employment growth as well as provide a level of care for the 21st century. Two potential sites were identified for the new acute hospital: the redevelopment of the current site on Hardwick Lane and a site at Westley. A full consultation was carried out by the borough council.
Potential complications at Westley were recognised and West Suffolk Council assisted the Trust in identifying a further 19 sites. Each of these sites had the potential to house a new district general hospital, and four were shortlisted and appraised, and a preferred site selected.

Announcing the preferred site
Following three months of detailed surveys and technical assessments, stakeholders and staff were asked to appraise four shortlisted sites against a set of soft criteria that focused on access, proximity to amenities and the ability to support the integrated care system (ICS) strategy. These scores were collated and added to the weighted technical scores to arrive at an objective, independent preference. Key stakeholders involved in the appraisal included Suffolk County Council, district councils, parish councils, WSFT council of governors, Healthwatch Suffolk, staff unions and the Trust executive group. The selection of Hardwick Manor was communicated widely in a similar way to the purchase of the Hardwick Manor site.

The key differences were:

- video sessions were supported by sign language practitioners and recorded with subtitles added for the five most spoken languages in the area
- audio sessions were included to ensure the inclusion of the digitally challenged
- FAQs were developed based on queries raised on social media, and throughout the engagement sessions. The FAQ section of the webpage received 500 visits within the first five days
- bespoke engagement events were arranged for local residents with separate engagement events organised for the wider community.

The key message was that Hardwick Manor was the preferred site and that the Trust was continuing to explore another potential site in detail. It was stressed that formal planning permission would not be sought until later in 2021.

Engagement will be ongoing throughout the beginning of 2021 to ensure everyone in the community is able to have a say and that investigations are able to continue into an alternative option. The Trust felt that keeping this option open was essential in ensuring that it continues to stay true to the co-production ethos and genuinely provide opportunities for patients and the community to apply their experience to shape the outcome of the programme.

The Future System team has met with a variety of stakeholders including the Bury Residents Association and further meetings are planning with similar groups across Suffolk, South Norfolk and Breckland.

When the engagement ends, Healthwatch Suffolk will undertake analysis and evaluation of the feedback gathered. This will allow a fresh unbiased perspective on the comments received and the mitigations presented.

Planning consultation
The team aims to submit planning permission at the end of 2021. As part of this application an Environmental Impact Assessment needs to be included. The Environmental Impact Assessment pre-scoping report has been submitted to the council and letters have been sent to all residents in the vicinity inviting them to discuss the content. Pre-planning and planning consultation are planned for June, July, October and November 2021.

Clinical services engagement

The clinical services in the hospital building based at Hardwick Lane have been split into 12 co-production workstreams, each with their own lead(s), recruited from the WSFT workforce. The leads are forming planning groups to include the views and ideas of all the people who have an interest or viewpoint in each service.

Each workstream includes between 10 and 12 people and aspire to include one or two patients, with the remainder of the group to include clinical and operational staff relevant to the workstream. Co-production leads are also tasked with working with peers and partners across the system to develop something fit for the future, fit for now and fit for the healthcare system as a whole.

Four elected lay members will work across all workstreams to capture and represent the views of patients who access the system regularly; those who access the services intermittently and those who will access our services in the future. The latter includes children and young people up to the age of 18; adults with lower level of use between the ages of 19 and 59; adults with higher level of use between the ages of 19 and 59 and all adults aged over 60 years.

The co-production process facilitates a number of workshops, each working through a designated toolkit. These toolkits will be replicated into an online survey and distributed to stakeholders, patient groups and members of the public. The toolkits will be used as a basis for discussion in bespoke focus groups and meetings, and to involve staff so that their views are captured at each stage. Various open team meetings will be held alongside briefings using existing internal communication channels.

On 1 March 2020 an online survey capturing patients', visitors' and staff views about clinical services, technology, and their ambition about how our services could look in the future was launched. This activity is a part of our ongoing co-production and will result in clinical service visions that have been created with our patients, staff and wider community. Posters were placed across the Hardwick Lane and community sites advertising the opportunity to staff, patients, and visitors. We also worked with numerous stakeholders such as voluntary sector organisations; the ICS; clinical commissioning groups in both Norfolk and Suffolk; Norfolk and Suffolk district councils; parish and county councils; patient participation groups (PPGs), Healthwatch Suffolk and charities to engage staff, patients, clients, and users. This phase will continue until the end of July 2021 and will be supplemented with bespoke discussions held with the community engagement group.

One element of our overall communications and engagement strategy is to implement engagement opportunities which patients and staff can complete while, for example, waiting for an appointment or taking a break at work. To make sure these engagement opportunities are as safe as possible we are working with the infection, prevention and control team. Items we are looking to implement include iPads in waiting areas, 'thought trees' and suggestion boards.

It is important that we hear and include views from a range of perspectives and are undertaking the following to achieve this:

- We have presented to the Forest Heath Disability Forum and have been working with Learning Disability Charity ACE to develop easy read versions of our materials. They will also be working with us to host workshops adapted to those with learning disabilities. To capture those with physical and mental disabilities and not just learning difficulties we are in discussion with the Suffolk Coalition of Disabled people about the areas they may be able to facilitate and support. The Speech and Language Therapy (SALT) team within the Trust are assisting in ensuring communications are aphasia friendly from both a staff and patient perspective.
- We are working with our system colleagues at Suffolk County Council to target specific audience groups such as the homeless, rough sleepers and street sex workers to capture marginalised voices.
- We continue to team up with our Communities & Families colleagues at West Suffolk Council, Babergh and Mid-Suffolk Council and South Norfolk Council to extend our reach and capture those seldom heard.
- We are collaborating with our system associates to capture the voices of younger audiences and will be holding bespoke sessions with the Youth Advisory Group and the Western Assembly of Youth. We are also in discussion with several schools regarding carrying out workshop sessions as part of lessons and presenting in school assemblies. The opportunity to join the online survey and the community engagement group has also been extended to the parents of both primary and secondary pupils.
- We are in discussions with the West Suffolk Maternity Voice Partnership to ensure we capture the aspirations and concerns from new and expectant parents recognising that many will also be parents to siblings and able to feed into the paediatric workstream.

Community Engagement Group and Peer Review Panel

Whilst there is a governance structure in place, which is important for a project of this magnitude, there is an understanding and support for the co-production process throughout the project. This approach is not just an ethos but is a way of working which will hopefully be replicated Trust wide.

Peer review panel

Each of the co-production work streams is focusing on its service area working with patients, clinical and operation staff. Prior to it being presented to the programme board an independent peer group will provide a holistic view of the proposals from a staff and clinical perspective. The panel will provide knowledgeable peer review scrutiny of the methodology used and the recommendations generated from each of the workstreams. This provides a sense check against other policy mandates, prevailing trends and background intelligence.

The panel will comprise a designated deputy from each of the Trust executive directors to ensure that each director can have confidence in the recommendations being made. They will also provide an unbiased and independent assessment in scrutinising and approving recommendations.

The members of the panel are as follows:

- deputy chief operating officer
- deputy chief nurse
- a deputy medical director
- a suitable deputy for the director of integration
- a deputy director of workforce
- a deputy director of finance.

Once recommendations have been validated, they can be sent to external partners for any additional suggestions and inputs. On final endorsement of recommendations, papers can be submitted for approval to the programme board for ratification. Papers will then be submitted to the WSFT Board for final approval.

Community engagement group
To sit alongside this and provide an independent view from a community and patient perspective this group has been established, comprising:

- a local resident
- a representative for vulnerable groups inc. homeless, sex workers, prisoners and those with severe mental illnesses
- those with caring responsibilities
- BAME and LGBT representatives
- recruited project lay members
- Patient VOICE representatives (our patient, public and family carer representative group)
- independent experts such as;
    - disability and accessibility advocates
    - union representatives
- Youth Council member
- governing body engagement committee members
- members of the general public
- voluntary sector member
- community group representative.

The group discusses proposals before they are presented to the project board for final decision. They are advocates for the project and our eyes and ears in the community. This group meets on an ad hoc basis but as a minimum of every six weeks and has a rolling membership meaning that those who have requested to join the group do not have to attend every meeting.

We ask for people to express an interest in joining the group, and each meeting comprises different individuals with an interest in the matters being discussed at that meeting. However, it is important that a broad representation of views can be heard at every meeting.

The ethos of co-production is embedded in the future system programme. One of the key elements of this is developing clinical and design proposals with our patients, stakeholders such as governors and the community – working with those it affects the most.

In March 2021, we introduced the community engagement group (formerly known as the co-production community engagement group). To date we have more than 150 members of the community engagement group who we can call on to participate in bespoke focus groups and workshops to develop our clinical visions.

The VOICE group assisted in developing a new name for the group and it was renamed the community engagement group.

Other engagement activity The Trust has engaged closely with its key external stakeholders throughout the programme including system partners, NHS England and NHS Improvement, Suffolk and North East Essex ICS and the Department of Health and Social Care. All of these stakeholders have representatives on the programme board and have played an active role in the governance of the programme. Other key groups with which we have a close relationship are:

- VOICE patient representatives - the four elected volunteer patient VOICE reps will not only form a part of the community engagement group but they will be assisted in developing their own engagement hubs. These will be specific to their target audience demographic and include individuals, organisations and places where they can discuss ideas, share thoughts and capture the voice of that demographic to bring to the co-production community engagement group. We work closely with the patient experience team providing updates on a bi-weekly basis and ensuring any patient experience learning gathered through our engagement work or through their patient experience routes is shared.

- West Suffolk Alliance engagement group - the West Suffolk Alliance, in conjunction with West Suffolk CCG, is setting up a West Suffolk Alliance engagement group. The group will provide patient and public perspectives on ICS related activities. It is important to include not only patient perspectives but also community views in alignment with other system projects in our developments. It is proposed that members of this group sit on the community engagement group. Regular meetings are also arranged with the ICS engagement team to ensure any opportunities are shared and there are no conflicts with planned activity. Health Overview and Scrutiny Committee task and finish group - Suffolk HOSC is a key stakeholder which will be briefed regularly. To ensure members receive the information they feel is relevant, a task and finish group has been established. This group will meet every six weeks to discuss the developments and decide what the committee needs to be briefed on. Regular written briefings will be supplied to Norfolk HOSC and Cambridgeshire HOSC reflecting the wide patient demographic which WSFT serves.
- Project identity - from the very beginning staff and the wider community have been involved in every decision, including the naming of the project. This project is more than bricks and mortar and the Trust wished to capture the hearts and minds of the people to whom this project will mean the most. Suggestions were requested for a project name and strapline from both staff, volunteers, patient representatives and members of the local community. The co-produced result was ratified by the community engagement group, HOSC task and finish group, peer review group, primary care group and members from the West Suffolk Alliance.

Accessibility

All communication and engagement activity has had accessibility considered and employed mitigations where possible. The Trust will continue to create items which can be accessed and understood by all including working with adult speech and language therapist colleagues in terms of language and layout.

The Trust will host briefings online which will be recorded and feature subtitles in various languages. As soon as restrictions allow, briefings will be held face to face to widen the reach of engagement as far as possible. These will be held at various times to ensure maximum participation by all audiences and members of the community.

The Trust is working with system partners to reach those seldom heard including rough sleepers, homeless, sex workers, refugees, asylum seekers, gypsy, traveller and Roma community and the younger audience.

Bespoke sessions will be held which are accessible for those with learning disabilities or severe mental and physical disabilities.

Public consultation

Although the proposed clinical vision produced at the strategic outline case stage and the selection of the preferred site does not require consultation as set out in NHS England guidance, it is acknowledged that as the development of the clinical model evolves this may involve changes to services in order to, for example, deliver more care closer to home as supported by the NHS long-term plan and ICS strategy. The outline model does not currently indicate significant service transformation or reconfiguration which would require formal public consultation. Throughout the development of the outline business case this model will be refined and should the clinical model propose substantial changes to service, a formal public consultation will be launched.

While the preferred site has been announced, the Trust is continuing to explore other avenues and has not ruled out other locations depending on feasibility. The current recommendation of Hardwick Manor as the Trust's preferred site means that the location of services provided by the Trust will not be significantly changed and thus the need for formal public consultation is not currently necessary. The decision as to whether to consult in the future will remain open until such time as there are any decisions about changes to the location, at which point a formal consultation will be launched.

For any formal consultation, the Trust will follow the advice to hold this over a minimum of 12 weeks to make sure it is in line with best practice guidelines.

Communications

Website
A dedicated website has been launched at https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx.

The website features engagement opportunities, up to date information on the programme including news updates, frequently asked questions and contact details.

Newsletter
A newsletter has been launched and more than 300 people have subscribed to it, with the first edition due to be launched in the next quarter.

Communication with residents
It is important for the programme team to maintain transparency and build good relations with our close neighbours. To this end, regular communications have been sent to local residents, particularly relating to milestones and updates which may impact them. Feedback routes are also made clear allowing the relationship to be mutually beneficial.

Stakeholder briefings
Briefings are supplied to key stakeholders at each milestone, providing clear and transparent information which may be of interest.

2.2.9 Other disclosures

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

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

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

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

Political donations
The Trust did not make any political donations during 2020/21.

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 £0 of interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2020/21 (2019/20 £58).

	2020/21		2019/20	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	47,952	199,575	59,655	145,747
Total non-NHS trade invoices paid within target	35,411	160,185	24,787	86,932
Non-NHS trade invoices paid within target (%)	**73.8%**	**80.3%**	**41.6%**	**59.7%**
Total NHS trade invoices paid in the year	1,477	21,357	2,035	45,966
Total NHS trade invoices paid within target	664	13,177	503	32,919
NHS trade invoices paid within target (%)	**45.0%**	**61.7%**	**24.7%**	**71.6%**

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 CBE
Chief executive
29 June 2021

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).

The Board was not fully compliant with code requirement B.1.2 that at least half the board of directors, excluding the chairperson, should comprise non-executive directors as there was a gap between the end of Gary Norgate's term of office on 31 May 2020 and David Wilkes' appointment from 31 July 2020.

2.4 NHS Improvement's single oversight framework

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

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

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

Segmentation

The Trust has been placed in segment 2, the second best category. This segmentation information is the Trust's position as at 17 May 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

2.5 Statement of accounting officer's responsibilities

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS 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 CBE
Chief executive
29 June 2021

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2020 to 31 March 2021

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 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

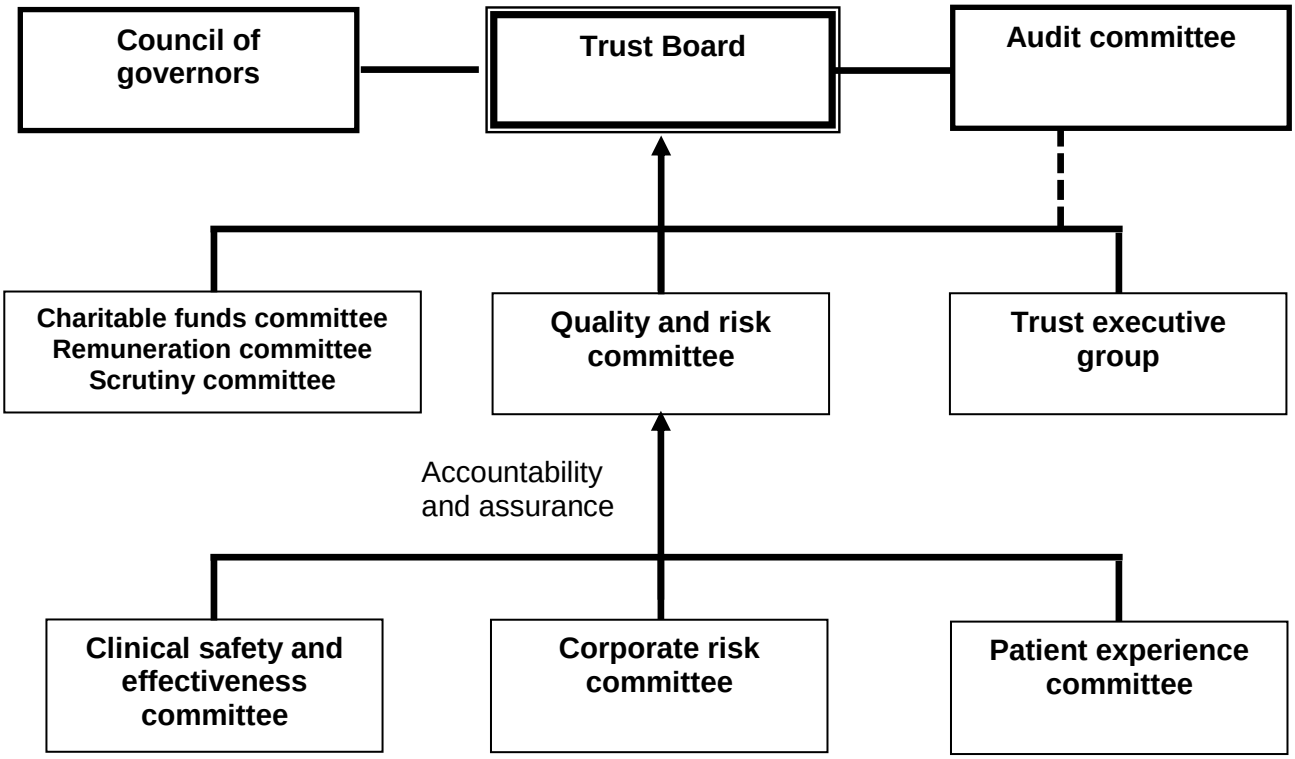
The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to foundation trusts. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust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

During the year the organisation reviewed its governance structure and the roles and responsibilities of the board committees. As a result an updated governance committee structure has been agreed and will be implemented in Q1 of 2021/22.

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 2020/21 and this will be further developed during 2021/22.

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

- Performance management framework
- Monthly quality and performance reports, statistical process control (SPC) charts and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints, 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
- Quality walkabouts, including executive directors, non-executive directors and governors have not been possible due to the social distancing requirements of Covid-19. During these restrictions executives, non-executives and governors colleagues have engaged with staff through virtual meetings, including the regular all staff briefing
- 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 2020/21
- **Maintaining status of global digital exemplar**
- **Excellent reputation for teaching** – both undergraduate and graduate.

It has been an unprecedented and challenging year for the Trust, the NHS, the nation and the world, but there are many achievements to be proud of.

We employ more than 5,000 staff in both hospital and community healthcare settings and what they have achieved this year has been truly inspiring. The challenges of working in the NHS through a pandemic while dealing with the restrictions we have all faced, has made doing all we can to support staff wellbeing more important than ever.

As part of our well-being programme, we have expanded our staff psychology support service allowing the team to offer one to one support as well as briefings for all through our Wellbeing Wednesday sessions, looking in depth at issues affecting many people. A partnership with Abbeycroft Leisure has given our employees free access to online and in-person sports facilities close to their homes, and has seen about 1,500 members of staff signing up. In February the communications team organised “Love Yourself”, a week of online well-being events from Pilates to cooking. All of these sessions were recorded so they could be watched at any time by our busy colleagues and there have been over 1,000 viewings.

We have also provided the tools for those colleagues who were able to work from home, allowing them to stay in touch with their colleagues and the rest of the Trust. Weekly virtual all-staff briefings have allowed us to keep people informed and address concerns they may have. We have ensured our teams have the equipment they need to protect themselves, and introduced stringent processes to minimise transmission of the virus. Staff have also been able to access free hot drinks, hot food at night and free car parking.

Our My WiSH Charity is celebrating its 25th anniversary this year, and the dedicated team has worked tirelessly throughout the pandemic. From welfare packs for staff who need them, to calm spaces where people can take a break, they have provided practical help and support. In recent years, the Charity has raised over one million pounds annually to improve patient care and support our staff. Having helped fund major projects such as the development of Rainbow Ward and the cardiac centre, My WiSH Charity has been an incredible part of our Trust. Recently they have funded a registered play specialist who helps our youngest patients feel safe and reassured when they come into hospital.

Our WSFT workforce is a diverse one, and we strive to reflect this with a number of networks that help us meet the individual needs of all those who work for us. Our LGBT+ and disability networks were joined this year by a Black and Minority Ethnic network – we look forward to learning from these colleagues in the future.

Within our trust improvement programme, improving our culture is a priority, especially in the wake of a disappointing Care Quality Commission (CQC) report last year. Our CQC improvement plan has included a greater focus on encouraging people to feel able to speak up on matters of concern to them. These are some of the principles of the Civility Saves Lives project and Merseycare Just Culture training which we have taken on board and learnt from over the last year.

We are early adopters of the new national Patient Safety Incident Response Framework, which will update the way we respond to and investigate incidents. We are involved in the pilot run by NHS England with regional partners and commissioners which we hope will be rolled out nationally when the pilot comes to an end. As part of introducing the framework, the Trust's patient safety team is developing an incident response plan which will help us identify the most significant patient safety risks, and ensure learning is put in place.

We have been joined this year by Natalie Bailey in the newly-created role of head of mental health. An experienced registered mental health nurse, Natalie will be working across the WSFT in both our hospitals and community services, and with partners and services.

Meanwhile our countywide community services continue to provide excellent care to people closer to their homes, whether that may be a speech and language therapist working in a special school; or a district nurse helping to manage the pain relief for a patient at the end of their life. The integrated community teams; pathway one and enhanced support initiatives have proved the value of joined-up working, not just within the Trust but also with the wider system. Teaming up with social care and

other providers has enabled us to provide improved care for patients, while also saving thousands of bed days at the hospital.

At our community hospital in Newmarket we have provided extra beds to help provide flexibility in the fight against Covid-19. We recruited new staff, including the first registered nursing associate at the Trust – a pioneering NHS role which contributes to the core work of nursing, supporting registered nurses to focus on more complex clinical care. The introduction of a portering team at the hospital has also improved the care we can offer patients and is proving a welcome support to staff.

At the West Suffolk, patients with Covid-19 or other infectious conditions can now be treated in specialist facilities at the new major assessment area within our emergency department. The 10-bed facility, made possible by a £2.7m Government grant, has separate treatment rooms designed to allow for isolation of patients while they are assessed.

While the My WiSH Charity provided free reusable cups to every staff member as a thank you, and also to cut down on waste, we installed more LED lighting to save money and resources.

This year has seen demands made on our IT and digital teams as never before. As well as providing equipment and processes to enable staff to work from home, the IT team has supported clinical teams to use every digital platform available to keep in touch with patients. For example, our community cardiac rehabilitation team, unable to run their exercise classes, supported patients on Zoom.

This year has seen the transition of all our community colleagues on to the WSFT IT network, a project that has seen significant investment both financially and in terms of time and expertise. Providing new digital equipment and smartphones and bringing these teams in line with their hospital-based colleagues has improved the working lives of staff across the Trust.

The West Suffolk community view in e-Care, our electronic patient record system, also known as the health information exchange, is now being widely used, most recently having been rolled out through our maternity services, and is a valuable tool in integrated working. Digital tools have helped us care for our patients and their families during the pandemic, when we have been forced to restrict visits from loved ones. We set up a Keeping in Touch and clinical helpline service to provide information and reassurance and keep patients in contact with their loved ones and also introduced a free entertainment and media system that patients could use from a smartphone or tablet.

Despite the pandemic, a number of our services have achieved national recognition. Our stroke team retained its top grade A ranking for the ninth year in a row. Researchers at King's College London review data from hospitals across the country as part of the Sentinel Stroke National Audit Programme, assessing stroke care against 41 key indicators.

For the tenth successive year, the radiology department has been accredited with the Quality Standard in Imaging (QSI) by the United Kingdom Accreditation Service (UKAS). Another dedicated team received recognition for its work gathering and sharing data from our orthopaedic services. The award of National Joint Registry (NJR) Quality Data Provider for 2019/2020 demonstrates the high standards being met.

The community cardiac rehabilitation team met all seven key performance indicators to achieve accreditation from the British Association for Cardiovascular Prevention and Rehabilitation. This uses data from the National Audit of Cardiac Rehabilitation to quality assure services in the UK.

The Royal College of Physicians Joint Advisory Group on endoscopy has awarded its highly-sought after professional accreditation to our endoscopy services, which use high-tech cameras to film inside the body to help with diagnosis and treatment.

Finally, our catering team received two accolades – the Health Business Awards Hospital Catering Award; and recognition of the high quality of its food in a national report on catering in the NHS led by former Great British Bake Off judge Prue Leith.

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

After a challenging few years for colleagues in our pathology labs, we were pleased to welcome back to the Trust more than 100 pathology services staff, bringing the service in-house.

Our Trust continues to work in our wider community and with other system partners. With Glemsford Surgery, we have embarked on a special project to improve patient care, and have officially joined as integrated partners in healthcare. From the buildings to the staff, we will support the surgery and work together to create a new, innovative, strong and sustainable healthcare service in Glemsford and the west of Suffolk.

Partnerships such as this will prove more important as we develop our Future Systems programme, to deliver not only a new hospital, but sustainable and integrated healthcare for our community. As part of our plan to develop a new healthcare facility, we have purchased Hardwick Manor and have begun the process of planning and co-production. In the meantime, our estates team continue to work incredibly hard to make sure our current hospital remains fit for purpose until we can move into the healthcare facility.

Of course, in a year when Covid-19 has put the NHS under incredible strain, all of our staff have gone above and beyond to serve our community and look after those in the greatest need. As we look back, one of the key highlights of the last year has been the amazing team work across the Trust and the support and friendship given to one another.

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

- **Staff engagement and raising concerns**
- **Building structure**
- **Covid-19 response and access**

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	Safety and quality, leading to potential harm, governance or service failure, leading to reputation damage, poor patient experience and 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
	Failure to manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan	Patient safety. Reputational impact and poor patient experience/satisfaction. Regulatory action. Negative impact on staff wellbeing

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
	Delivery of elective access standards based on clinical priorities, in context of Covid activity and delivery of the RAAC remediation plan	Poor care and treatment of patients. Loss of public and GP confidence. Negative impact on staff wellbeing.
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.
	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 NHSE/I). 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	Quality and safety and reputation impact. Adverse employee relations and staff motivation. CQC regulatory action. Withdrawal of Royal College recognition. Failure to achieve reduction in non-contracted pay as part of financial plans. Poor staff engagement hinders delivery of transformation and efficiency. Inability to recruit/retain key staff
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 funding to the local health system
	WSFT is a key partner in the Alliance and is actively shaping and contributing to the delivery of the Alliance strategy	Ability to deliver safe and sustainable services for local population. Local position leads to tension between local health economy partners. Loss of funding to the local health system. Loss of confidence in WSFT and west Suffolk system

Board assurance framework summary

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 review and oversight by the chief nurse and medical director to ensure that effective systems are in place.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). 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 2020/21 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 is subject to independent review by internal audit.

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

- Effectiveness of governance structures – which are subject to annual review and recommendations for improvement monitored through an agreed action plan
- Responsibilities of directors – directors' objectives and performance are regularly monitored by the remuneration committee
- Responsibilities of subcommittees - are considered as part of the annual governance review and the quality and risk committee and audit committee provide an annual report to the Board on their activities and performance
- Reporting lines and accountabilities between the Board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the Board and executive team
- Submission of timely and accurate information to assess risks to compliance with the Trust's licence
- Degree and rigour of oversight the Board has over the Trust's performance – the Board continually reviews and develops its reporting arrangements to the Board. The monthly quality and performance report for the Board supports an open reporting culture and includes the results from the Friends and Family Test; the 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 assessment for 2020/21 will be submitted in June 2021 and we anticipate a satisfactory score of 42/42 assertions being met consisting of 110 mandatory evidence items. An independent audit of the assessment has been commissioned by NHS Digital and the Trust is committed to addressing the remedial actions identified prior to the submission in June.

The Trust reported one data breach to the Information Commissioner's Office (ICO) in 2020/21, this involved the loss of an unencrypted computer hard drive. The action plan suggested by the ICO is currently being considered.

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 to 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. During the Trust's Covid response reporting to the Board was amended to maintain the required oversight but recognising that many of the normal activity and access indicators were not meaningful.

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

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the 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 updated in 2017, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the Board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Internal audit reported 10 reports from the 2020/21 plan; the "opinion levels" are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	3
Substantial assurance - controls are suitably designed, consistently applied and operating effectively.	1
Reasonable assurance - identified issues that need to be addressed	4
Partial assurance - action is needed	2
No assurance - urgent action is needed	0

The conclusions from the two partial assurance internal audit reports are set out below and action to address the concerns have been reviewed by the audit committee:

- **Fit and Proper Persons** (partial assurance) – areas of weakness related to instances of missing documentation to support that the required checks had been undertaken. Additionally, the ability to consistently evidence that the Companies House Disqualification Register and the Government database had been checked to confirm the Director was not insolvent or bankrupt, that a Self-Declaration Form had not always been signed prior to the commencement of the Director's appointment, and that the annual Self-Declarations Forms were not being consistently completed.

- **Nursing - Temporary Staffing & Rostering** (partial assurance) - areas of weakness related to the Staff Rostering for All Clinical Areas Policy and the Staffing Escalation for Nursing Policy having not been reviewed in line with the review timeline (although this was in progress at the time of the audit). In terms of requesting temporary staff common themes were identified in terms of retrospective input of shifts within Healthroster, non-compliance with Trust's defined request lead time, and bank staff were not always sought in the first instance before resorting to agency referrals. It was also noted that, due to the historical paper retention of timesheets, the auditors were unable to obtain 80 percent of the timesheets for sample testing. The audit also identified that audit trails of overtime requests and authorisation decisions are not maintained, aside from emails that could be deleted and lost. During the course of the audit, improvement initiatives were

observed in line with the Improvement Plan for improving rostering practices of the Trust, including a new eight-week lead time and introduction of e-timesheets. The audit team were assured by a well-designed and consistently applied process for producing rosters and sound governance arrangements in respect of monitoring rostering performance via monthly Check and Challenge meetings with the Deputy Chief Nurse and reporting to the Board.

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 2021, the head of internal audit's opinion for WSFT is that: "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

External audit reports that the annual report and accounts are true and fair.

In preparing this annual governance statement, as required under NHS foundation trust conditions, all relevant internal and external 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:

- **Staff engagement and raising concerns**

  The development of a culture where all staff feel confident to speak up and raise concerns at work is crucially important to us. We affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement.

  In the summer of 2020 we conducted a major engagement exercise with staff asking 'what matters to you' and the results of the survey and focus groups was fed back to the Board, and throughout the organisation. Its themes provided the framework for our first 'West Suffolk People Plan', which has been delivered.

  In 2020 we enhanced our Freedom to Speak Up Guardian function by appointing two individuals to the role and ensuring each has allocated time to promote speaking up and supporting those who raise concerns. Additional support will be provided by a cohort of Freedom to Speak Up Champions, recruited from across the organisation, and working with our Guardians to further encourage and support a speaking up culture. We have made speaking up training available to all managers and staff.

  From the 2020 NHS Staff Survey results we know that further work is required to develop this culture, given that an increased number of colleagues reported that they did not feel confident to speak up.

  The NHS Staff Survey was undertaken during October and November 2020, as per the usual annual timetable. Rather than limiting the survey to a sample, West Suffolk again took the decision to give all staff the opportunity to take part. Around 2,000 staff took part, a response rate of 46%. The 2020 staff Survey results are being shared at a wider level across the organisation and to develop our response. This has included presenting the themes at various forums with staff and staff representatives. Further analysis was undertaken to understand the range of results, to ensure that actions are targeted at the areas that need specific support, and we celebrate and learn from the staff groups/teams that are reporting a positive experience.

Our new team of HR Business Partners, (an investment secured in 2020 on the back of our increased commitment to support teams and improve management culture), are working with their respective divisions and corporate directorates to ensure results are worked through and plans are developed to respond to specific priorities. At an organisational level we have used the results to develop the next iteration of our West Suffolk People Plan. Two workshops have taken place engaging with staff representatives, ambassadors and supporters in developing the plan.

West Suffolk has embarked on our just, learning and restorative culture journey which is progressing positively. We invested in a group of 10 colleagues to attend the Northumbria University/Mersey Care training – the group included our CEO, HR Director, Union colleagues, HR, Patient Safety leads and senior managers from across the organisation. A review of priority HR policies has been undertaken with a change on emphasis and language; this being the language used is reflective of a supportive, kind and compassionate approach with the emphasis on informal resolution and learning. We recognise the stress for staff resulting from the need to participate in, or contribute evidence for incidents, inquests and complaints and are establishing additional systems designed specifically to support staff in these circumstances.

We also anticipate the publication of the report of the independent rapid review commissioned by the Department of Health and Social Care into whistleblowing concerns and will address the issues requiring action as a priority.

- **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.

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 it. These mitigations are: recommended by structural engineers, well-managed, and reported to our regulators as part of our planned estates works.

The need for a new hospital has been nationally acknowledged and WSFT, and the rest of the west Suffolk health system, were delighted that the Trust was named as one of 40 to benefit from the Government's New Hospital Programme. However, whilst this news is very much welcome, any new facility will not be open for several years and we have a duty to ensure that the existing hospital is appropriately maintained and we are able to continue to provide high quality health services for our community.

In 2019 an additional, specific structural risk was identified about a product called reinforced autoclaved aerated concrete (RAAC) planks, which were used in the original build of West Suffolk Hospital and the front residences in the 1970s.

The alert received was from the Standing Committee on Structural Safety (SCOSS), which reported one sheer RAAC plank failure in a non-NHS site built of similar material and construction. The alert recommended that inspection work be carried out on buildings of RAAC construction, giving guidance on how to further assess the condition and structural adequacy of the planks.

Our estates teams have been proactive, robust and on the front foot in tackling this issue.

Since receiving the alert, they have mapped every plank across the organisation, and implemented an assessment programme using sophisticated radar equipment and other approved tests to check all planks for signs of stress. The teams are carrying out remedial repairs across the estate as part of this; work has not stopped throughout the pandemic.

The Trust has engaged experienced structural engineers and experts to support the inspection work. All planks will be continually assessed in a rolling programme of routine estates work. In

addition, we have proactive programmes of precautionary maintenance work to further ensure the safety of our patients, visitors, and staff.

We are not complacent - this has and will continue to have our absolute attention and focus. Staff, patient and visitor safety matters to us above all else.

This issue has not been caused by a failing of the Trust, which has managed its estates repairs well within the means available, but by the ageing of a product in our roof that cannot be replaced. We want to be transparent about our challenges and to reassure our patients, staff and community.

The programme of works to inspect the building structure and implement required mitigating action continues and we have received additional funding to support the programme during 2021/22.

- **Covid-19 response and access (including referral to treatment (RTT) and cancer)**

As we move into 2021/22 there is a requirement for us to deliver increased levels of elective activity to clear backlogs against a backdrop of endemic levels of Covid-19 in society. Compounding this issue is the now real impact on capacity as we undertake the RAAC plank end-bearing and failsafe programmes. As a result, it is no longer appropriate to consider these as separate risks and challenges.

Access, including referral to treatment (RTT), diagnostics and cancer

The Trust has faced two significant waves of Covid-19 which have had a consequent negative impact on all elective waiting times. Between the 2 waves we started to recover services and developed significant learning which enabled a more rapid recovery following the second wave. The requirements of social distancing, enhanced infection control and personal protective equipment (PPE) have had a negative impact on the capacity of all services. The national planning guidance for 2021/22 recognises this and has set expectations for trusts to achieve activity below their 2019/20 baseline within existing resources with opportunities to secure additional funding for the delivery of activity above this level.

As part of the Suffolk & North East Essex (SNEE) Integrated Care System (ICS), we submitted a bid and were successful in being designated as an elective recovery accelerator system. This has secured additional funding into the system to support the delivery of additional activity and also a comprehensive transformation plan in line with the expectations of the national planning guidance for 2021/22 to achieve sustainable services for the future. As an accelerator site we are required to deliver 100% of 2019/20 activity by July 2021 and 120% by September 2021. This is a system target which recognises the challenges of our remedial estates programme over the summer. Other accelerator systems are required to deliver 120% by July 2021.

The programme offers opportunity to provide a rapid increase in elective capacity, and thus reducing the longest elective care waits, and to address long standing access barriers, such as transformation of the outpatient service model. Notwithstanding these opportunities the current capacity reduction (as a result of the bearing extension and failsafe programmes) is a significant hurdle.

Priority 1: Capacity
This focuses on critical capacity increase and productivity initiatives. The delivery model has been built via a combination of standalone service initiatives and specific capacity increases. These can be summarised as:

  - An increase in theatre capacity via the procurement of a vanguard theatre (located at Ipswich hospital)
  - Maximising independent sector capacity across the region

- Additional CT, MRI and endoscopy capacity to improve diagnostic waiting times
- Day case and theatre reprofiling – this includes productivity initiatives and rescheduling main theatre activity in the day surgery unit
- Increased weekend working in both main theatres and day surgery
- Review of infection prevention and control (IPC) guidance to facilitate increased throughput
- Additional schemes are being reviewed and worked up, such as elective super surge weekends.

Priority 2: Transformation
This focuses on transformation and the delivery of workstreams that transform service delivery so as to meet the needs of service users both now and in the future. In this way the programme is supporting both elective recovery (now) and service delivery post pandemic (future).

The transformation programmes include the following initiatives:

- A comprehensive outpatient development programme (which includes work on digital transformation, advice and guidance, patient initiated follow up (PIFU) amongst others.
- Nationally identified pathways which can be considered high volume, low complexity (HVLC) (29 designated pathways in the following specialties - Cardiology, T&O/MSK, Ophthalmology, Gynaecology, ENT, General Surgery and Urology).
- Identified opportunities to deliver joint management of waiting lists.
- Patient choice and transfer of clinical care between providers.
- Reduced long waits, particularly of those cohorts of patients waiting the longest (52+ weeks.)
- Clinical validation to ensure consistent clinical prioritisation across all points of delivery.
- Improved patient optimisation in primary and secondary care with a focus on health inequalities.
- Productivity opportunities via review of available benchmarking data (such as model hospital and GIRFT).
- Workforce, including recruitment programmes and development of new and expanded roles.

Priority 3: Sustainability
This focuses on sustainability and the creation of a framework in which success is achieved and informs future service configuration. This includes formalised success metrics, reporting, benchmarking and performance management. There are clear synergies between the elective accelerator programme and the future system work and both teams are keen to take a joined up and collaborative approach. It is important that we avoid duplication and engage our clinical teams once collectively, rather than separately or in an uncoordinated way.

Covid-19 – operational response and impact

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 personal protective equipment (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 CBE
Chief executive
29 June 2021

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 was one new appointment to an executive role during 2020/21. 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 NHS Improvement 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 which support the Trust's priorities
  - scrutinising the objectives of the executive directors (to be established by the chief executive and to support the Trust's priorities) and review performance reports on the executive directors prepared by the chief executive
- scrutinise the recommendations of the clinical excellence awards committee
- review the terms of reference of the committee every two years
- report the frequency of meetings and the members of the remuneration committee in the Trust's annual report
- the committee shall report in writing to the Board the basis for its recommendations
- consider the Trust's equality, diversity and inclusion policy in all decisions made, the objectives of which are linked to the Trust's overall strategy. Further detail regarding diversity and inclusion is provided within the staff report (see page 88 for further details on this policy)

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. Four meetings of the remuneration committee were held during 2020/21.

Attendance at remuneration committee meetings

Name	Title	Attendance (out of 4)
Sheila Childerhouse	Trust chair	4
Richard Davies	Non-executive director	4
Angus Eaton	Non-executive director (remuneration committee chair)	4
Rosemary Mason[(1)]	Associate non-executive director	1 (of 1)
Gary Norgate[(2)]	Non-executive director	0 (of 0)
Louisa Pepper	Non-executive director	3
Alan Rose	Non-executive director	3
David Wilkes[(3)]	Non-executive director	4

Meeting dates: 12 August 2020, 8 October 2020, 19 October 2020 and 16 February 2021

[(1)] Rosemary Mason was appointed as associate non-executive director from 24 August 2020
[(2)] Gary Norgate resigned as non-executive director on 31 May 2020
[(3)] David Wilkes was appointed as non-executive director on 31 July 2020

Senior managers' (executive directors') pay is annually reviewed by the remuneration committee. The committee is presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS market in the context of pay awards to other staff groups. Decisions to increase salaries are based on this information, internal equity, affordability,

whether there has been a significant change in a director's portfolio and thus responsibility. Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable, including any senior manager paid more than £150,000. In addition, each director can receive the NHS cost of living pay rise which is based on the national NHS pay award. In recent years the Department of Health and Social Care has advised the chair on the expected level. The arrangement for managing the remuneration policy for senior managers was strengthened from 2018/19 to include engagement with staff and public governors.

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

The senior managers' salary does not include separate components and there are no performance measures that apply. Clinical elements are included in the salary of the Medical Director as part of the work undertaken in their medical role.

Service contracts obligations

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

- chief executive – six months
- executive directors – three months.

The non-executive directors hold a term for 3 years. Further details can be found on page 45 of this report.

Policy on payment for loss of office

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

Annual report on remuneration

In the financial year the directors' costs increased to £1,286k from £1,197k. There were no exit packages paid to Board members in the 2020/21 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.

	2020/21		2019/20	
	Directors	Governors	Directors	Governors
Total number in office during the year	15	39	13	25
Total number receiving expenses	4	0	8	8
Aggregate total of expenses paid during the year (£)	3,994	0	14,211	1,805

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 2020/21 was £185k - £190k (2019/20, £185k - £190k). This was 7.8 times (2019/20, 7.6 times) the median remuneration of the workforce, which was £24,157 (2019/20, £24,616). This is calculated based on all staff employed, including agency nursing staff covering vacancies, as at 31 March 2021. The ratio has not changed significantly year on year.

In 2020/21, nine employees (2019/20, seven employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £18,005 to £224,242 (2019/20 £17,652 to £218,196).

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 2021				Year to 31 March 2020			
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2500)	Total (bands of £5000)	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	Increase in pension entitlement (bands of £2500)	Total (bands of £5000)
	£000	£00	£000	£000	£000	£00	£000	£000
Mrs H Beck - chief operating officer	125 - 130	1	30 - 32.5	155 - 160	120 - 125	1	80 - 82.5	205-210
Mr C Black – executive director of resources	165 - 170	68	0 - 2.5	170 - 175	140 - 145	96	42.5 - 45	195 - 200
Ms J Bloomfield – executive director workforce & communications (Note 1)					25 - 30	-	-	25 - 30
Mrs S Childerhouse - chair	45 - 50	2	-	45 - 50	45 - 50	1	-	45 - 50
Dr R Davies - non executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr S Dunn – chief executive	185 - 190	128	70 - 72.5	270 - 275	180 - 185	109	32.5 - 35	225 - 230
Mr A Eaton - non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr N Jenkins - medical director (Note 2)	190 - 195	-	22.5 - 25	210 - 215	185 - 190	2	72.5 - 75	255 - 260
Mrs R Mason - non-executive director (Note 3)	5 - 10	-	-	5 - 10				
Mr G Norgate – Non-executive director (Note 4)	0 - 5	-	-	0 - 5	10 - 15	-	-	10 - 15
Mr J Over – executive director workforce & communications (Note 5)	120 - 125	-	20 - 22.5	140 - 145	45 - 50	-	10 - 12.5	60 - 65
Mrs L Pepper - non-executive director	10 - 15	-	-	10 - 15	10 - 15	1	-	10 - 15
Ms R Procter – executive chief nurse (Note 6)	25 - 30	15	0 - 2.5	30 - 35	115 - 120	83	10 - 12.5	135 - 140
Mr A Rose - non-executive director	10 - 15	14	-	15 - 20	10 - 15	-	-	10 - 15
Mr D Wilkes - non-executive director (Note 7)	5 - 10	-	-	5 - 10				
Mrs S Wilkinson - executive chief nurse (Note 8)	25 - 30	-	147.5 - 150	170 - 175				

No additional performance pay and bonuses were paid in 2020/21 or 2019/2020.

Table B – Pension benefits to 31 March 2021

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 2021 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash equivalent transfer value at 1 April 2021	Real increase in cash equivalent Transfer Value	Cash equivalent transfer value at 31 March 2020
	£000	£000	£000	£000	£000	£000	£000
Mrs H Beck (Note 9)	0 - 2.5	5 - 7.5	45 - 50	140 - 145	0	0	0
Mr C Black (Note 12)							
Dr S Dunn (Note 10)	2 - 5.0	0 - 2.5	80 - 85	0	1039	80	943
Dr N Jenkins (Note 11)	0 - 2.5	0 - 2.5	40 - 45	80 - 85	685	38	636
Mr J Over (Note 11)	0 - 2.5	0 - 2.5	30 - 35	60 - 65	478	27	444
Ms R Procter (Note 11)	0 - 2.5	0 - 2.5	30 - 35	60 - 65	526	14	503
Mrs S Wilkinson (Note 11)	5 - 7.5	17.5 - 20	40 - 45	125 - 130	954	170	771

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

Notes

1. 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. R Mason started as a NED in August 2020.
4. G Norgate left May 2020.
5. J Over was appointed as executive director of workforce and communications in November 2019.
6. R Proctor left June 2020.
7. D Wilkes started as a NED in July 2020.
8. S Wilkinson was seconded to the role of executive chief nurse in June 2020 and fully appointed in January 2021.

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

10. Lump sum is zero as a member of 2008 section and 2015 section which does not provide an automatic lump sum.

11. Lump sum increase may be zero or low as now a member of 2015 scheme which does not provide an automatic lump sum.

12. The executive director of resources opted out of the NHS Pension Scheme in January 2020. As the member is no longer active in the pension scheme there are no figures available to calculate by the NHS Pension Agency.

Dr Stephen Dunn CBE
Chief executive
29 June 2021

2.8 Staff report

2.8.1 Our staff

The Trust is one of the largest employers in the west of Suffolk, employing 4,879 staff in April 2021. It firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2020/21 with the following activities:

- the Trust achieved an above average rating for comparable trusts for the staff engagement theme in the 2020 national NHS staff survey
- the percentage of staff recommending WSFT as a place to work in the 2020 national NHS staff survey was well above average for comparable trusts
- our two Freedom to Speak Up Guardians, 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 on these
- as part of the Trust's health and wellbeing programme we continue to focus on both emotional and physical health and wellbeing. In 2020/21 we set up a clinical psychologist-led staff support psychology service and introduced a wide range of benefits to support staff during the COVID-19 pandemic. We developed an individual staff risk assessment tool to support our staff in the risks they face from occupational exposure to COVID-19. This tool has been updated regularly as our understanding of the virus has developed
- staff continue to receive financial assistance in the form of low-interest loans which are arranged by an external organisation, and have access to a staff physiotherapist
- all staff have access to free membership of Abbeycroft Leisure which includes access to physical facilities and virtual classes
- all staff were offered both an influenza and COVID-19 vaccination in 2020/21
- we have continued to support the trade union convenor role and undertaken a significant range of activity to access the opinions and suggestions of our staff. This included a major staff engagement exercise, 'What Matters to You", in the summer of 2020. We conducted a survey of our medical staff seeking their feedback on their experience of the COVID-19 pandemic first wave
- we continue to develop our partnership working through the following committees:
  - Trust council
  - 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	2020/21 Total £000	2019/20 Total £000
Salaries and wages	167,201	520	**167,721**	143,039
Social security costs	16,229	-	**16,229**	14,160
Apprenticeship levy	792	-	**792**	696
Employer's contributions to NHS pensions [1]	27,485	-	**27,485**	25,137
Pension cost - other	66	-	**66**	51
Temporary staff	-	4,329	**4,329**	5,792
Total staff costs	**211,773**	**4,849**	**216,622**	188,875
Of which				
Costs capitalised as part of assets	3,596	342	**3,938**	4,280

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

	Permanent number	Other number	2020/21 Total number	2019/20 Total number
Medical and dental	491	48	**539**	494
Administration and estates	763	44	**807**	759
Healthcare assistants and other support staff	801	136	**937**	883
Nursing, midwifery and health visiting staff	1,145	89	**1,234**	1,129
Scientific, therapeutic and technical staff	649	13	**662**	583
Total average numbers	**3,849**	**330**	**4,179**	**3,848**
Of which:				
Number of employees (WTE) engaged on capital projects	99	4	**103**	73

2.8.4 Reporting of compensation schemes - exit packages 2020/21

There were no compensation schemes/exit packages recorded in 2020/21. There was one non-compulsory departure payment recorded for 2020/21 with a value of £63,150.

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

	Male	Female	Total
Executive directors (including CEO)	5	2	7
Non-executive directors (including chair)	4	3	7
Other senior managers (band 8d and above)	8	6	14
Employees	898	3,822	4,720

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
25	22.82
Percentage of time spent on facility time	**Number of employees**
0%	21
1%-50%	3
51% - 99%	1
100%	0
Total cost of facility time	**Costs**
Total pay bill	£210,981,000
Percentage of pay bill spent on facility time	0.011%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
1,222	2.5%

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 fora 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. Progress towards our equality, diversity and inclusion objectives can be seen in the inclusion plan published on our website.

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			
	2020/21	2019/20	2018/19	2017/18	2020/21	2019/20	2018/19	2017/18
Age								
16	0	0	0	0	0	0	0	0
17-21	75	54	64	49	60	71	51	65
22+	4673	4299	3981	3765	6077	6,105	5,800	5,854
Not specified	0	0	0	0	114	120	123	126
Total	4748	4353	4045	3814	6251	6,296	5,974	6,045
Ethnicity								
White	3765	3500	3382	3182	5540	5,600	5,331	5,391
Mixed	55	49	44	40	32	34	29	28
Asian or Asian British	485	461	312	264	106	95	88	90
Black or Black British	60	29	31	27	28	28	23	23
Other ethnic group	48	39	42	39	34	35	30	30
Not stated	186	198	213	257	511	504	473	483
Undefined	149	77	21	5	0	0	0	0
Total	4748	4353	4045	3814	6251	6,296	5,974	6,045
Gender								
Female	3833	3544	3281	3111	3953	3,932	3,673	3,684
Male	915	809	764	703	2298	2,364	2301	2361
Total	4748	4353	4045	3814	6251	6,926	5,974	6,045
Disability								
No	2436	2104	1770	1557		-	-	-
Not declared	325	365	327	356		-	-	-
Undefined	1370	1227	1276	1798	5670	5,661	5,338	5,386
Prefer not to answer	455	516	558	-	-	-	-	-
Yes	162	141	114	103	581	635	636	659
Total	4748	4353	4045	3814	6251	6,296	5,974	6,045

Source: Electronic Staff Record (as at 1/4/2021)

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 2020 here.

The Trust seeks to provide equitable employment opportunities for people with disabilities, ensuring that they benefit from all available training and opportunities for career development and has a policy to support the recruitment and retention of people with disabilities. Additionally, our policy on appraisal, personal development planning and the knowledge and skills framework supports and promotes the equal access of all staff to training and development.

The Trust has systems and processes in place to review staff turnover. Information for the year is available via https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

2.8.9 Health and safety report

The Trust's health and safety performance is reported to and monitored by the health and safety committee which then escalates any issues of concern (accountability is now via the newly established insight committee). Issues that cannot be resolved or which need to be escalated are reported to the trust executive group and the Board of directors accordingly.

Risk assessment

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

During 2020/21 a further 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 of Public Health Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. 244 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 2020 and March 2021 a total of 21 incidents were reported to the Health and Safety Executive (HSE) as required under RIDDOR. This is the same number of incidents as the previous year.

There were no RIDDOR reportable incidents relating to asbestos. There was a slight increase in the category of moving and handling from six to seven incidents; slips, trips and falls from six to seven incidents, violence and aggression from two to four incidents and needlestick incidents from zero to two.

RIDDOR description	2020/21
Moving and handling incidents	7
Slips, trips and falls	7
Needlestick	2
Violence and aggression	4
Struck by moving/falling object	1

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

- policy and procedure for handling patients and safe handling of loads all front-line staff attend mandatory moving and handling training via e-learning and classroom sessions
- access to moving and handling advisor and trainer
- all wards and departments are required to have moving and handling risk assessments.

Of the 21 incidents reported to the HSE, 17 incidents (81%) involved a staff member being off work for more than seven days following an incident. The health and safety committee reviews incident trends, including RIDDORs, to ensure that appropriate learning takes place and action is taken.

Incident reporting system

The Datix incident reporting system is used to capture all clinical and non-clinical incidents. Non-clinical incidents include reports of personal accidents, violence and aggression, abuse and harassment, fire, and security breaches. All incidents, no matter the grade, are investigated and reported according to the Trust's incident policy and procedure. Actions taken as a result of investigations are communicated through the divisional governance groups. The Board of directors receives a quarterly report summarising incident trends and action.

For the period April 2020 to March 2021 there were 337 violence, abuse and harassment incidents – an increase of 35 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Out of the 337 incidents reported there were 133 physical assaults, and 93 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.

There were 1,780 reported incidents of personal accident/ill-health during 2020/21. This is an increase of 15 incidents (1%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories. These include, slips, trips and falls; contact with an object; contact with a sharp object, e.g. needle; moving 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:

To 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 have worked successfully with our partner Oh: Occupational Health and Wellbeing to deliver our agreed priorities for health and wellbeing. The programme is led and overseen by the Trust health and wellbeing steering group. We will be working with a new provider of occupational health and wellbeing services from October 2021 when the partnership with Oh:Occupational Health and Wellbeing ends.

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 since the start of the COVID-19 pandemic has been on supporting the emotional and physical wellbeing of our staff. We have set up a clinical psychologist led staff psychology support service that has supported hundreds of members of Trust staff both individually and in teams.

Our occupational health team developed an individual staff risk assessment tool to support our staff in the risks they face from occupational exposure to COVID-19. This tool has been updated regularly as our understanding of the virus has developed.

All our staff have had easy access to both an influenza and COVID-19 vaccination through our inhouse vaccination programmes.

2.8.11 Staff survey

The NHS staff survey is run on an annual basis across the service in England. It is one of the largest staff feedback and benchmarking exercises for any employer in the world. A set of standard questions is used, with each Trust required to appoint an independent survey contractor to administer the process, collate results and submit these to the national staff survey centre. This then leads to all Trusts receiving a standardised report which benchmarks them against their own historical performance, and against comparator organisations. The Trust is benchmarked against other Acute and Acute & Community Trusts.

The staff survey provides deep insights into the views and experiences of our staff. We use the results to understand our current position and involve our teams in how the report's findings are interpreted and taken forward.

Staff support and 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:

- all-staff briefing – weekly live briefing and Q&A with executives
- 'What Matters to You' survey – staff discussion workshops during the pandemic
- monthly team briefings
- Freedom to Speak Up guardians
- 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
- electronic staff briefing issued at least once a week
- monthly medical director's bulletin for medical staff
- the Green Sheet weekly staff newsletter
- the 5 o'clock club - our leadership and culture development forum
- staff recognition programme
- staff health and wellbeing focus groups
- staff networks – LGB&T+, BAME and disability networks
- 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

From 2019 onwards, the results from questions were grouped to give scores in 10 indicators. The quality of appraisals is no longer measured as a theme. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

In the majority of the themes the Trust is considered to be average or above average, the majority of those are above average. The Trust has fallen below average in three areas, previously they had been considered average or just above average.

	2020		2019		2018	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.1	9.1	9.3	9.0	9.3	9.1
Health and wellbeing	6.2	6.1	6.4	5.9	6.4	5.9
Immediate managers	6.9	6.8	7.2	6.8	7.0	6.7
Morale	6.4	6.2	6.6	6.1	6.4	6.1
Quality of appraisals	-	-				
Quality of care	7.5	7.5	7.7	7.4	7.6	7.5
Safe environment – bullying and harassment	8.0	8.1	8.2	7.9	8.1	7.9
Safe environment – violence	9.4	9.5	9.4	9.4	9.4	9.4
Safety culture	6.6	6.8	7.1	7.0	7.0	6.6
Staff engagement	7.2	7.0	7.5	7.0	7.4	7.0
Team working	6.6	6.5	6.9	6.6	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.

	2020/21	2019/20	2018/19	2017/18	2016/17
Response rate	45.7%	51.8%	48.4%	47.9%	50.1%
Benchmarking group	45.4%	47.5%	44.4%	44.2%	42.8%

Best and worse scores against benchmarking

Best scores

	2020/21		2019/20		2018/19	
Indicator	**Trust**	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
Q18d > If friend/relative needed treatment would be happy with standard of care provided by organisation	**82.6%**	**74.3%**	86.3%	70.5%	82.9%	71.0%
Q18c > Would recommend organisation as place to work	**73.8%**	**66.9%**	76.7%	62.9%	74.2%	62.3%
Q19c > As soon as I can find another job, I will leave this organisation	**11.1%**	**13.2%**	10.8%	14.4%	11.9%	15.0%
Q19b > I am unlikely to look for a job at a new organisation in the next 12 months	**16.3%**	**18.7%**	16.2%	19.9%	17.1%	20.6%
Q11e > Not felt pressure from manager to come to work when not feeling well enough	**21.2%**	**26.3%**	19.9%	24.2%	19.1%	25.4%

Worst scores

Indicator	2020/21		2019/20		2018/19	
	Trust	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
Q11g > Have you put yourself under pressure to come to work?	**94.2%**	**93.0%**	93.2%	92.3%	95.1%	92.4%
Q16c > When errors, near misses or incidents are reported, my organisation acts to ensure that they do not happen again.	**70.3%**	**72.7%**	78.5%	70.7%	77.6%	69.9%
Q16d > We are given feedback about changes made in response to reported errors, near misses and incidents	**58.5%**	**61.9%**	67.1%	61.2%	65.2%	59.0%
Q17b > I would feel secure raising concerns about unsafe clinical practice	**69.1%**	**71.8%**	74.8%	70.8%	71.5%	69.8%
Q17c > I am confident that my organisation would address my concern	**54.8%**	**59.1%**	66.6%	58.9%	63.3%	57.4%

Next steps on our journey

The 'What Matters to You' staff engagement programme in 2020, developed and led by our staff for our staff, set a new bar for the scale and depth of how staff's views and experiences directly inform our improvement plans.

Our first 'West Suffolk People Plan' in 2020 was built around the wants and needs of our staff, based on their feedback during the first wave of the pandemic. It enabled us to focus on what was most important at an unprecedented time.

The West Suffolk People Plan will be strengthened further as a result of the 2020 staff survey results, again ensuring there is collaboration with staff on what would make the most difference to them. Furthermore, our clinical divisions are delving deeper into the results to understand areas of strength and potential for improvement, to ensure that local action plans are tailored to specific needs.

2.8.12 Pension liabilities for ill-health retirement

There were two ill-health retirements during the year to 31 March 2021 (2019/20: one); the additional pension liability borne by NHS Pensions was estimated as £120k (2019/20: £35k).

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 (2021)01, the Trust must disclose information regarding off-payroll engagements.

Highly paid off-payroll engagements as at 31 March 2021 earning £245 per day or greater:

No. of existing engagements as of March 2021	7
Of which:	
No. that have existed for less than one year at the time of reporting	1
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	2
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	4

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater:

No. of off-payroll workers engaged during the year ended 31 March 2021	1
Of which:	
Not subject to off-payroll legislation	1
Subject to off-payroll legislation and determined as in scope for IR35	0
Subject to off-payroll legislation and determined as out of scope for IR35	0
No. of engagements reassessed for compliance or 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, between 1 April 2020 and 31 March 2021:

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.	29

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 2020 and 31 March 2021.

During 2020/21, the Trust spent £365k on consultancy costs (2019/20 £458k). Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

2.8.15 Other disclosures

Other relevant disclosures for this section of the annual report are including within section 2.2 (directors report).

West Suffolk NHS Foundation Trust

Annual Accounts for the year ended 31 March 2021

Contents Page

Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2021, 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 **29 June 2021**

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 2021, 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 interpreted and adapted by the 2020-21 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2020-21, and the NHS Foundation Trust Annual Reporting Manual 2020-21 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 2021 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 2020-21; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

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

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

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.

Opinion on the Remuneration Report and Staff Report

Qualified 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.

Except for the matter referred to in the Basis for qualified opinion on information in the Remuneration Report and Staff Report paragraph of our report, 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 2020-21.

Basis for qualified opinion on information in the Remuneration Report and Staff Report

The Remuneration Report does not include the required pension benefit disclosures for one senior manager who is a deferred member of the NHS pension scheme and for whom no contributions in 2020/21 were made. The Trust has been unable to obtain the required information in respect of this individual from NHS Pensions, the administrator of the scheme, and is unable to obtain this information from other sources. This matter results in the information included in all the columns of the Pensions table and the pension information included in the remuneration table for 2020/21 being incomplete for these senior managers in question.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accounting Officer

As explained in the Statement of Accounting Officer's responsibilities, the Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

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 Accounting Officer's Responsibilities in respect of the Accounts, 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.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Our procedures included the following:

- inquiring of management, and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Trust's controls relating to Managing Public Money requirements;
- discussing among the engagement team and involving relevant internal specialists, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, posting of unusual journals and cut off of expenditure around year-end;
- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. The key laws and regulations we considered in this context included the National Health Service Act 2006, as amended by the Health and Social Care Act 2012. Other relevant laws and regulations identified include VAT legislation, PAYE legislation, the NHS Group Accounting Manual and Foundation Trust Annual Reporting Manual.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantively testing an increased sample of expenditure around the year end; and

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

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

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

Certificate - delay in completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the West Suffolk NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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 Schedule 10 of the National Health Service Act 2006 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.

DocuSigned by:
Rachel Brittain
945F22100B63425...

Rachel Brittain
For and on behalf of BDO LLP, Statutory Auditor
London, UK

29 June 2021

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

Audit Completion Certificate issued to the Council of Governors of West Suffolk NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 29 June 2021 we explained that the audit could not be formally concluded until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

This work has now been completed and we have reported the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report.

No matters have come to our attention since 29 June 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in this respect.

Certificate

We certify that we have completed the audit of West Suffolk NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 and Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

DocuSigned by:
Rachel Brittain
945F22100B63425...

Rachel Brittain, Director
For and on behalf of **BDO LLP**, Statutory Auditor
London, UK

09 September 2021

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 2021

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	264,518	241,576
Other operating income	4	56,764	41,597
Operating expenses	6	(104,081)	(102,812)
Employee benefits	8	(212,684)	(184,595)
Operating surplus/(deficit) from continuing operations		**4,517**	**(4,234)**
Finance income		3	83
Finance expenses		(2,378)	(2,443)
PDC dividends payable		(2,832)	(897)
Net finance costs		**(5,207)**	**(3,257)**
Other gains / (losses)		(42)	19
Share of profit / (losses) joint arrangements		-	(145)
Deficit for the year		**(732)**	**(7,617)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments - taken to revaluation reserve	7	(574)	(3,198)
Revaluations		2,605	-
Gain arising from transfers by modified absorption		-	8,531
Other reserve movements		30	-
Total comprehensive income / (expense) for the period		**1,329**	**(2,284)**
Adjusted financial performance (control total basis):			
Deficit for the period		(732)	(7,617)
Remove net impairments not scoring to the Departmental expenditure limit		1,075	7,894
Remove I&E impact of capital grants and donations		6	105
Remove 2018/19 post audit PSF reallocation (2019/20 only)		-	(280)
Remove net impact of inventories received from DHSC group bodies for COVID response		(187)	-
Adjusted financial performance surplus		**162**	**102**

Statement of Financial Position as at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	11	52,198	40,972
Property, plant and equipment	12	135,703	110,593
Investment property		1,400	-
Receivables	13	6,341	5,707
Total non-current assets		**195,642**	**157,272**
Current assets			
Inventories		3,481	2,872
Receivables	13	19,362	32,342
Cash and cash equivalents	14	23,788	2,441
Total current assets		**46,631**	**37,655**
Current liabilities			
Trade and other payables	15	(52,522)	(33,692)
Borrowings	16	(6,439)	(58,529)
Provisions		(46)	(67)
Other liabilities		(1,357)	(1,933)
Total current liabilities		**(60,364)**	**(94,221)**
Total assets less current liabilities		**181,909**	**100,706**
Non-current liabilities			
Borrowings	16	(47,719)	(52,538)
Provisions		(852)	(744)
Total non-current liabilities		**(48,571)**	**(53,282)**
Total assets employed		**133,338**	**47,424**
Financed by			
Public dividend capital		158,650	74,065
Revaluation reserve		8,743	6,942
Income and expenditure reserve		(34,055)	(33,583)
Total taxpayers' equity		**133,338**	**47,424**

The notes on pages 111 to 143 form part of these accounts.

Name Dr Stephen Dunn CBE
Position Chief Executive Officer
Date 29 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**74,065**	**6,942**	**(33,583)**	**47,424**
Deficit for the year	-	-	(732)	**(732)**
Other transfers between reserves	-	(230)	230	**-**
Impairments	-	(574)	-	**(574)**
Revaluations	-	2,605	-	**2,605**
Public dividend capital received	84,585	-	-	**84,585**
Other reserve movements	-	-	30	**30**
Taxpayers' and others' equity at 31 March 2021	**158,650**	**8,743**	**(34,055)**	**133,338**

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)	**-**
Other transfers between reserves	-	(195)	195	**-**
Impairments	-	(3,198)	-	**(3,198)**
Public dividend capital received	4,952	-	-	**4,952**
Taxpayers' and others' equity at 31 March 2020	**74,065**	**6,942**	**(33,583)**	**47,424**

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 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,517	(4,234)
Non-cash income and expense:			
Depreciation and amortisation	6	7,518	7,259
Net impairments	7	1,496	7,903
Income recognised in respect of capital donations	4	(371)	(245)
(Increase) / decrease in receivables and other assets		12,678	(11,011)
Increase in inventories		(609)	(174)
Increase in payables and other liabilities		14,464	5,314
Increase in provisions		85	651
Net cash flows from / (used in) operating activities		**39,778**	**5,463**
Cash flows from investing activities			
Interest received		3	83
Purchase of intangible assets		(12,983)	(9,289)
Purchase of PPE and investment property		(27,526)	(12,173)
Sales of PPE		6	28
Net cash flows used in investing activities		**(40,500)**	**(21,351)**
Cash flows from financing activities			
Public dividend capital received		84,585	4,952
Increase in loans from DHSC		-	17,902
Repayment of loans from DHSC		(56,258)	(3,769)
Increase in other loans		1,000	218
Repayments of other loans		(440)	(280)
Capital element of finance lease rental payments		(1,287)	(1,884)
Interest on loans		(1,525)	(2,131)
Interest paid on finance lease liabilities		(981)	(279)
PDC dividend paid		(3,025)	(907)
Net cash flows from financing activities		**22,069**	**13,822**
Increase / (decrease) in cash and cash equivalents		**21,347**	**(2,066)**
Cash and cash equivalents at 1 April - brought forward		**2,441**	**4,507**
Cash and cash equivalents at 31 March	14	**23,788**	**2,441**

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust achieved an adjusted financial surplus position during the financial year and is forecast to breakeven in the forthcoming year.

The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.3 Interests in other entities

The Trust has a 25% share in Collaborative Procurement Partnership Limited Liability Partnership (LLP) with three other NHS Organisations. The LLP was established in 2017/18 and the investment in this is not yet material to the Trust. Therefore assets have not been reflected in the accounts. No income has been accrued for in 2020/21 as no profits are expected to be distributed (loss of £145k in 2019/20).

MyWish charity has not been consolidated into the Trust's accounts on the grounds of materiality.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, The Provider sustainability Fund (PSF) and Financial recovery fund (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.

Donated and grant funded assets

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

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

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

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	89
Dwellings	17	88
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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

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

Note 1.15 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.16 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 2022. 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 2022, 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 defined by HM Treasury. Currently this rate is 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 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 2022. Any new lease arrangements will also be reviewed in light of this standard.

Other standards, amendments and interpretations

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 1.17 Sources of estimation uncertainty

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

• **Equipment Deposits**: The Trust pays a deposit to an external company for equipment issued to patients in the community. If the equipment is returned and the company is able to re-use it, the deposit is returned. Based on experience in the last 5.5 years it is assumed that 74% of deposits outstanding at the balance sheet date will be recovered, which equates to £8.4 million for 2020/21.

• **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 2020/21. 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. The value of the Trust's land and buildings equates to £103.7m as at 31 March 2021. 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, the performance at a divisional level on a monthly basis. Segments are considered where the total income is 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. In 2020/21 the Trust received block contract income rather than income based on activity performed. As a result the majority of income is shown against the corporate function for 2020/21.

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.

2020/21	Medicine £000	Surgery £000	Women £000	Corporate £000	Community £000	Other £000	Total £000
Income	74,721	44,076	20,143	130,902	42,180	9,260	321,282
Expenditure	(78,773)	(54,655)	(19,964)	(58,778)	(46,616)	(57,979)	(316,765)
Contribution	**(4,052)**	**(10,579)**	**179**	**72,124**	**(4,436)**	**(48,719)**	**4,517**

2019/20	Medicine £000	Surgery £000	Women £000	Corporate £000	Community £000	Other £000	Total £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)**

These segments represent the management structure in the organisation. This note analyses total income by management unit within the Organisation.

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)	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	186,052	160,447
High cost drugs income from commissioners (excluding pass-through costs)	13,108	14,110
Other NHS clinical income	16,794	19,705
Community services		
Block contract / system envelope income*	29,571	28,041
Income from other sources (e.g. local authorities)	9,455	10,129
All services		
Private patient income	966	1,174
Additional pension contribution central funding**	8,222	7,368
Other clinical income	350	602
Total income from activities	**264,518**	**241,576**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	13,210	26,964
Clinical commissioning groups	240,537	203,113
Other NHS providers	8,104	8,493
Local authorities	1,351	1,230
Non-NHS: private patients	934	1,009
Non-NHS: overseas patients (chargeable to patient)	79	165
Injury cost recovery scheme	303	599
Non NHS: other	-	3
Total income from activities	**264,518**	**241,576**
Of which:		
Related to continuing operations	264,518	241,576

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

	2020/21	2019/20
	£000	£000
Income recognised this year	79	165
Cash payments received in-year	36	132
Amounts added to provision for impairment of receivables	216	176
Amounts written off in-year	9	125

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	565	-	**565**	609	-	**609**
Education and training	7,485	-	**7,485**	7,326	-	**7,326**
Non-patient care services to other bodies	16,224		**16,224**	16,909	-	**16,909**
Provider sustainability fund (2019/20 only)	-	-	**-**	4,419	-	**4,419**
Financial recovery fund (2019/20 only)	-	-	**-**	1,823	-	**1,823**
Marginal rate emergency tariff funding (2019/20 only)	-	-	**-**	4,153	-	**4,153**
Reimbursement and top up funding	24,791	-	**24,791**	-	-	**-**
Receipt of capital grants and donations	-	371	**371**	-	245	**245**
Charitable and other contributions to expenditure	-	3,859	**3,859**	-	-	**-**
Rental revenue from operating leases	-	118	**118**	-	125	**125**
Other income*	3,234	117	**3,351**	5,988	-	**5,988**
Total other operating income	**52,299**	**4,465**	**56,764**	**41,227**	**370**	**41,597**
Of which:						
Related to continuing operations			56,764			41,597

*Other income includes £400k of car parking (2019/20 £2m) and £600k of catering income (2019/20 £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:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	264,518	241,576
Income from services not designated as commissioner requested services	56,764	41,597
Total	**321,282**	**283,173**

Note 6 Operating expenses

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	81	89
Purchase of healthcare from non-NHS and non-DHSC bodies	1,743	1,596
Staff and executive directors costs	212,684	184,595
Remuneration of non-executive directors	127	119
Supplies and services - clinical (excluding drugs costs)	37,610	32,863
Supplies and services - general	3,239	4,603
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,825	22,033
Inventories written down	244	265
Consultancy costs	365	458
Establishment	3,893	4,550
Premises	8,264	5,492
Transport (including patient travel)	1,281	2,012
Depreciation on property, plant and equipment	5,179	4,972
Amortisation on intangible assets	2,339	2,287
Net impairments	1,496	7,903
Movement in credit loss allowance: contract receivables / contract assets	187	102
Increase/(decrease) in other provisions	13	32
Change in provisions discount rate(s)	117	-
Audit fees payable to the external auditor		
audit services- statutory audit*	62	45
Internal audit costs**	150	119
Clinical negligence	8,967	6,987
Legal fees	196	315
Insurance	156	124
Education and training	628	805
Rentals under operating leases	5,680	4,484
Car parking & security	27	357
Hospitality	22	21
Losses, ex gratia & special payments	-	100
Other	190	79
Total	**316,765**	**287,407**
Of which:		
Related to continuing operations	316,765	287,407

* The audit fees 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 £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	421	9
Changes in market price	1,075	5,647
Other	-	2,247
Total net impairments charged to operating surplus / deficit	**1,496**	**7,903**
Impairments charged to the revaluation reserve	574	3,198
Total net impairments	**2,070**	**11,101**

Impairments arose in 2020/21 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:

	Net Impairment
	£000
Main Hospital Block	691
Land	(66)
Other Buildings	1,445
Total	**2,070**

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 Oakfield surgery, a ward refurbishment and the roof replacement programme.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	167,721	143,039
Social security costs	16,229	14,160
Apprenticeship levy	792	696
Employer's contributions to NHS pensions	27,485	25,137
Pension cost - other	66	51
Temporary staff (including agency)	4,329	5,792
Total staff costs	**216,622**	**188,875**
Of which		
Costs capitalised as part of assets	3,938	4,280

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

Note 8.1 Retirements due to ill-health

During 2020/21 there were 2 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £120k (£35k in 2019/20).

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	5,680	4,484
Total	**5,680**	**4,484**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	632	1,257
- later than one year and not later than five years;	664	1,321
- later than five years.	647	8
Total	**1,943**	**2,586**
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 - 2020/21

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**1,490**	**45,578**	**9,256**	**56,324**
Additions	1,655	11,328	-	**12,983**
Reclassifications	-	9,838	(9,256)	**582**
Disposals / derecognition	-	(6,218)	-	**(6,218)**
Valuation / gross cost at 31 March 2021	**3,145**	**60,526**	**-**	**63,671**
Amortisation at 1 April 2020 - brought forward	**134**	**15,218**	**-**	**15,352**
Provided during the year	84	2,255	-	**2,339**
Disposals / derecognition	-	(6,218)	-	**(6,218)**
Amortisation at 31 March 2021	**218**	**11,255**	**-**	**11,473**
Net book value at 31 March 2021	**2,927**	**49,271**	**-**	**52,198**
Net book value at 1 April 2020	**1,356**	**30,360**	**9,256**	**40,972**

Note 11.1 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 - as previously stated	**1,490**	**45,545**	**-**	**47,035**
Additions	-	33	9,256	**9,289**
Valuation / gross cost at 31 March 2020	**1,490**	**45,578**	**9,256**	**56,324**
Amortisation at 1 April 2019 - as previously stated	**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 12 Property, plant and equipment - 2020/21

	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 2020 - brought forward	**7,900**	**74,237**	**10,690**	**6,830**	**17,744**	**4**	**9,962**	**135**	**127,502**
Additions	-	9,349	-	13,757	1,962	-	5,317	-	**30,385**
Impairments	(14)	(3,090)	-	-	-	-	-	-	**(3,104)**
Reversals of impairments	80	796	158	-	-	-	-	-	**1,034**
Revaluations	740	(842)	(110)	-	-	-	-	-	**(212)**
Reclassifications	2,164	1,633	3	(4,382)	-	-	-	-	**(582)**
Disposals / derecognition	-	-	-	-	(4,421)	(4)	(3,094)	-	**(7,519)**
Valuation/gross cost at 31 March 2021	**10,870**	**82,083**	**10,741**	**16,205**	**15,285**	**-**	**12,185**	**135**	**147,504**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**-**	**11,396**	**4**	**5,391**	**118**	**16,909**
Provided during the year	-	2,638	183	-	1,356	-	993	9	**5,179**
Revaluations	-	(2,634)	(183)	-	-	-	-	-	**(2,817)**
Disposals / derecognition	-	-	-	-	(4,372)	(4)	(3,094)	-	**(7,470)**
Accumulated depreciation at 31 March 2021	**-**	**4**	**-**	**-**	**8,380**	**-**	**3,290**	**127**	**11,801**
Net book value at 31 March 2021	**10,870**	**82,079**	**10,741**	**16,205**	**6,905**	**-**	**8,895**	**8**	**135,703**
Net book value at 1 April 2020	**7,900**	**74,237**	**10,690**	**6,830**	**6,348**	**-**	**4,571**	**17**	**110,593**

Note 12.1 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 - as previously stated	**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 - as previously stated	**-**	**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 12.2 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	10,870	77,449	10,741	16,205	2,332	8,771	8	**126,376**
Finance leased	-	11	-	-	3,675	94	-	**3,780**
Owned - donated/granted	-	4,619	-	-	898	30	-	**5,547**
NBV total at 31 March 2021	**10,870**	**82,079**	**10,741**	**16,205**	**6,905**	**8,895**	**8**	**135,703**

Note 12.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£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/granted	-	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 12.4 Revaluations of property, plant and equipment

A valuation exercise on the land and properties comprising the West Suffolk NHS Foundation Trust estate was carried out with a valuation date of 31 March 2021. This valuation was undertaken by an external Valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book').

Property, Plant and Equipment and Investment Properties on the Statement of Financial Position has a carrying amount of £137.1m. Within this, £103.7m 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 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 £4.7 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 £4.0 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 2021 £000	31 March 2020 £000
Current		
Contract receivables	14,362	27,087
Allowance for impaired contract receivables / assets	(365)	(211)
Deposits and advances	2,820	3,323
Prepayments (non-PFI)	1,034	916
PDC dividend receivable	330	137
VAT receivable	1,134	1,015
Corporation and other taxes receivable	47	75
Total current receivables	**19,362**	**32,342**
Non-current		
Deposits and advances	5,560	5,041
Other receivables	781	666
Total non-current receivables	**6,341**	**5,707**
Of which receivable from NHS and DHSC group bodies:		
Current	10,847	22,912
Non-current	781	666

Note 13.1 Exposure to credit risk

	31 March 2021 £000	31 March 2020 £000
Ageing of impaired financial assets		
90- 180 days	35	44
Over 180 days	330	167
Total	**365**	**211**

	31 March 2021 £000	31 March 2020 £000
Ageing of non-impaired financial assets past their due date (not including accruals)		
0 - 30 days	3,511	3,650
30-60 Days	439	253
60-90 days	262	578
90- 180 days	875	1,262
Over 180 days	1,593	1,203
Total	**6,680**	**6,946**

£4.9m of the non-impaired financial assets past their due date are owed by NHS organisations (£5.9m in 2019/20).

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.

	2020/21 £000	2019/20 £000
At 1 April	**2,441**	**4,507**
Net change in year	21,347	(2,066)
At 31 March	**23,788**	**2,441**
Broken down into:		
Cash at commercial banks and in hand	6	8
Cash with the Government Banking Service	23,782	2,433
Total cash and cash equivalents as in SoFP and SOCF	**23,788**	**2,441**

Note 15 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	11,078	10,738
Capital payables	6,650	2,860
Accruals	27,665	13,444
Social security costs	2,451	2,166
Other taxes payable	2,028	1,621
Other payables	2,650	2,863
Total current trade and other payables	**52,522**	**33,692**
Of which payables from NHS and DHSC group bodies:		
Current	8,632	6,472

Note 16 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC*	2,397	56,478
Other loans	441	332
Obligations under finance leases	3,601	1,719
Total current borrowings	**6,439**	**58,529**
Non-current		
Loans from DHSC	42,767	45,074
Other loans	2,865	2,414
Obligations under finance leases	2,087	5,050
Total non-current borrowings	**47,719**	**52,538**

* The balance for current loans from DHSC in 2019/20 includes £54m of interim revenue and capital loans which were converted to PDC during 2020/21.

Note 16.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**101,552**	**2,746**	**6,769**	**111,067**
Cash movements:				
Financing cash flows - payments and receipts of principal	(56,258)	560	(1,287)	**(56,985)**
Financing cash flows - payments of interest	(1,434)	(91)	(981)	**(2,506)**
Non-cash movements:				
Additions	-	-	206	**206**
Application of effective interest rate	1,304	91	981	**2,376**
Carrying value at 31 March 2021	**45,164**	**3,306**	**5,688**	**54,158**

Note 16.2 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 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 2021 £000	31 March 2020 £000
Gross lease liabilities	**5,688**	**6,769**
of which liabilities are due:		
- not later than one year;	3,601	1,719
- later than one year and not later than five years;	2,087	5,050
Net lease liabilities	**5,688**	**6,769**
of which payable:		
- not later than one year;	3,601	1,719
- later than one year and not later than five years;	2,087	5,050

	31 March 2021 £000	31 March 2020 £000
Mininum lease payments		
Within one year	4,968	2,490
Between one and two years	1,275	3,705
Between two and five years	2,154	3,304
	8,397	9,499
Future finance lease capital	(1,167)	(1,000)
Finance charges allocated to future periods	(1,542)	(1,730)
Net lease liabilities	**5,688**	**6,769**

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 (£3.4m in 2019/20).

Note 18 Clinical negligence liabilities

At 31 March 2021, £117,138k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2020: £101,138k).

Note 19 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	22,272	4,905
Intangible assets	10,033	9,988
Total	**32,305**	**14,893**

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 2021 £000	31 March 2020 £000
Not later than 1 year	2,558	2,403
After 1 year and not later than 5 years	1,200	3,503
Paid thereafter	-	273
Total	**3,758**	**6,179**

Note 21 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	31 March 2021 Held at amortised cost £000	31 March 2020 Held at amortised cost £000
Trade and other receivables excluding non financial assets	23,523	36,117
Cash and cash equivalents	23,788	**2,441**
Total at 31 March 2021	**47,311**	**38,558**

£11.6m of the Trust's financial assets relate to income owed from other NHS Organisations (2019/20: £23.6m). Of the remaining balance as at 31 March 2021, £8.4m relates to deposits recoverable when community equipment is returned based on the likely proportion that will be returned.

The remainder of the balance is money owed from non-NHS Organisations. The collection of this debt is monitored closely and the balance is impaired or written off when the collection looks unlikely.

There are no individually material debts owed by non-NHS Organisations and the risk profile of the asset is assessed as low, which is the same as in 2019/20.

Note 21.1 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	31 March 2021 Held at amortised cost £000	31 March 2020 Held at amortised cost £000
Loans from the Department of Health and Social Care	45,164	**101,552**
Obligations under finance leases	5,688	**6,769**
Other borrowings	3,306	**2,746**
Trade and other payables excluding non financial liabilities	48,043	**29,905**
Provisions under contract	19	**39**
Total at 31 March 2021	**102,220**	**141,011**

Borrowing excluding finance leases is at a fixed rate and, apart from £3.3m from a commercial loan provider, is from the Department of Health and Social Care.

Within trade and other payables excluding non financial liabilities, £8.6m (2018/19: £6.5m) 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 2019/20.

Note 21.2 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	55,609	89,632
In more than one year but not more than five years	16,935	19,701
In more than five years	40,431	43,462
Total	**112,975**	**152,795**

* In the prior year, this disclosure was prepared using discounted cash flows in error. The comparatives have been restated on an undiscounted basis.

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	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
East Suffolk and North Essex NHS Foundation Trust	11,347	10,932	6,720	6,933
NHS West Suffolk CCG	184,181	161,694	521	264
NHS Ipswich And East Suffolk CCG	22,332	22,217	-	26
NHS Norfolk & Waveney CCG	18,382	-	3	-
NHS South Norfolk CCG	-	16,181	-	2
NHS Cambridgeshire and Peterborough CCG	3,519	3,163	-	-
Health Education England	7,611	7,082	5	93
NHS England	45,716	32,894	118	94
NHS Resolution (formerly NHS Litigation Authority)	-	-	9,094	7,216
NHS Property Services	44	207	788	1,300
Total	**293,132**	**254,370**	**17,249**	**15,928**

	Receivables		Payables	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
East Suffolk and North Essex NHS Foundation Trust	1,256	1,129	2,927	1,253
NHS West Suffolk CCG	663	2,760	777	1,130
NHS Ipswich and East Suffolk CCG	741	188	-	-
NHS Norfolk & Waveney CCG	189	-	8	-
NHS South Norfolk CCG	-	297	-	153
NHS Cambridgeshire and Peterborough CCG	11	-	-	43
Health Education England	7	30	105	100
NHS England	5,313	15,090	319	23
NHS Resolution (formerly NHS Litigation Authority)	-	-	1	60
NHS Property Services	168	282	2,428	2,647
Total	**8,348**	**19,776**	**6,565**	**5,409**

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent £112k on behalf of the Trust on capital items plus a further £230k on revenue items (2019/20: £245k on capital items plus a further £292k on revenue items). At the year end the Charity owed the Trust £62k (2019/20 £85k).

The Trust has disclosed transactions with NHS bodies where the income, expenditure, receivable or payable balance is over £2 million.