The Ipswich Hospital NHS
NHS Trust

One Big Team...
Ipswich Hospital
Annual Report 2013/14











Our Passion, Your Care.

For our design this year, we have chosen to feature photographs of colleagues nominated in the Staff Awards of The Ipswich Hospital NHS Trust 2014.

Front cover photos:

Row 1

Dermatology
Nominee: Team of the Year Award

Amgad Ragheb, Pain Relief Consultant
Nominee: Living the Values Award

Radiotherapy Service Team
Nominee: Team of the Year Award

Row 2

Daniel Read, Estate Coordinator
Nominee: Support Colleague of the Year Award

Val Dyer, Volunteer
Nominee: Volunteer of the Year Award

Ian Olding, Ward Receptionist – Martlesham Ward
Winner: Living the Values Award

Row 3

Aris Saoulidis, Pharmacist
Nominee: Support Colleague of the Year Award

Emergency Department
Nominee: Team of the Year Award

Celia Steward, Nuclear Medicine
Highly Recommended: Clinician of the Year Award

Row 4

Lauren Filbey, Specialist Registrar – Child Health
Nominee: Trainee Doctor of the Year Award and Clinician of the Year Award

Hospital School Teachers
Nominee: Team of the Year Award

Ryan Wood, Specialty Trainee in Trauma and Orthopaedics
Winner: Trainee Doctor of the Year Award

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

Polish język polski

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

Portuguese Português

Se pretende obter un pequeno resumo deste documento, ou caso pretenda que todo o documento seja treduzido para outro idioma, por favor peça a um colega que fale Inglês para nos contactar através do número 01473 704770.

Chinese 中文

如果您希望该文件的简短摘要或者全文翻译成其它语言，请让一位能讲英语的朋友拨打01473 704770 联系我们。

Bengali বাংলা

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

Kurdish کوردی

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

Farsi فارسی

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

Nicola Hemmingway, Doctor in Training
Winner: Living the Values Award

Contents

This Annual Report has been prepared in accordance with the requirements set out in the 2013/2014 NHS Trust Manual for Accounts.

The Quality Account 2013/14 is a companion document to this report and is available online at www.ipswichhospital.nhs.uk

Generic Research Team
Nominee: Team of the Year Award

Welcome

Chair's Foreword

This year The Ipswich Hospital NHS Trust laid a solid foundation towards becoming a hospital for the future. We have engaged in a widespread transformation process designed to create a sustainable, high quality, high performing provider of healthcare to a growing population with complex care needs.

Our significant progress and solid operational achievements are testimony to the success of the transformation programme to date.

However the year was not without challenges, most notable of these being the constrained financial environment of the NHS as a whole, together with the need to provide seven-day clinical services to the highest possible standard.

The ongoing partnership we have developed with our commissioners, together with internal restructuring to emphasise clinical leadership, has created the best conditions locally for meeting these challenges.

Our notable achievements include investing almost £8 million in new services. National funding of almost £1 million enabled us to develop a complex care suite and to transform two further wards into safer, warmer and caring environments for people with dementia.

Ann Tate CBE,
Chair.

The Medical Director of NHS England, Sir Bruce Keogh, opened our cutting edge simulation centre. The £250,000 East Anglian Simulation and Training Centre includes high fidelity medical simulation equipment and facilities. It has been developed to increase patient safety through improved clinically led education and training. The hospital matched a generous donation from the Dinwoodie Settlement Charity.

We are extremely proud of the high standard of medical learning and teaching provided by our consultants and the whole health care team. The standards have been validated by Health Education East of England which oversees the quality of education and training.

In addition, we have all been very proud of colleagues who have been nationally recognised for their outstanding contributions in their field. Sarah Higson, our Patient Experience lead, was awarded the NHS East of England Leadership Award for Community Champion.

Sally Ryan, one of our specialist nurses who has devoted her career to working with people with learning disabilities, has won a top national award – Patient Experience Professional of the Year.

The Radiotherapy VERT (virtual environment radiotherapy training) team has also won a prestigious award for their use of 3D scans to inform and help radiotherapy cancer patients.

In the pages which follow, you will find our strategic report and directors' report, outlining what we need to tell you about the way the hospital is managed and governed.

My thanks to all of the staff, volunteers and supporters of the hospital who every day work as part of a team of 3,700 people who make lives better for the community we serve.

Ann Tate CBE
Chair
31 March 2014

Chief Executive's Overview

I am immensely proud to be the chief executive of this hospital. This is my first year in the role and I am overwhelmed by the number of positive responses and comments I get from members of the public, often stopping me in the street. It is clear to me that this hospital has a huge place in people's hearts. Everyone who works here knows that affection is earned by delivering safe, high quality, compassionate care to patients.

I recognise that we don't get it right for everyone and that the great care we hear about most of the time, should be great care all of the time. We should be getting it right for every patient, every carer, every day. The journey we are taking to get to this point is outlined in the pages which follow.

A new management structure, to develop a clinically led organisation was introduced just at the start of our year in April 2013. We have been working with it for 12 months, and have just carried out detailed assessment interviews to evaluate its impact. It is fair to say that it is a work in progress, it is evident that it has made decision making a lot more objective, with more decisions taken closer to patients.

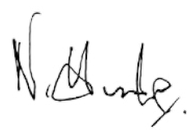
Nick Hulme,
Chief Executive.

A listening programme called The Future of Care involved hundreds of patients and staff in a series of In Your Shoes sessions. We asked patients about their experiences in this hospital so that we could build on and improve our services. A shared set of values and behaviours have developed from this work. These include patient promises, colleague promises and an explicit framework highlighting what anyone in our hospital will see. My thanks to everyone who took part in this vibrant and thoughtful programme.

Like many NHS hospitals, we have seen a marked increase in the need for health care with growing numbers of people needing urgent and immediate care. We are all extremely proud of the emergency department making consistent, sustained and highly recognised improvements, and becoming one of the top three hospitals in the country for performance, against this background of rising demand.

Another notable highlight of our year was HRH The Countess of Wessex formally opening The Ipswich Heart Centre, in March. We successfully planned, built and delivered this major new heart centre on time and on budget. The Sterile Services Centre is another new service. Both these developments which cost £10.8 million in total will make a real difference to patients and allow us to deliver services closer to home for the community we serve. I am going to be meeting the people we serve on a regular basis at a series of open forum. If you would like me to come to your area, let me know. You can also send me a message via my blog on our hospital website or use our Twitter account.

My best regards,



Nick Hulme
Chief Executive
31 March 2014

Strategic Report

Statutory Basis – background and content

The Ipswich Hospital NHS Trust is a National Health Service Trust providing hospital-based healthcare to more than 443,000 people who live in and around Ipswich and east Suffolk. The Trust is established under the NHS and Community Care Act of 1990. The Secretary of State for Health approved Trust status for Ipswich Hospital in April 1993.

The hospital is geographically located in the Suffolk county town of Ipswich, and administratively within the boundaries of Ipswich & East Suffolk Clinical Commissioning Group, Suffolk County Council and NHS Trust Development Authority Midlands and East.

It is a vibrant single-site, medium-size acute hospital, renowned for providing a high standard of specialist healthcare services to the residents of Ipswich and east Suffolk, and some specialties such as spinal surgery, radiotherapy and percutaneous coronary intervention (PCI) from September 2013 to a wider population, as well as outreach services in a number of clinical specialties.

The hospital has 552 beds (as of 31 March 2014) in general acute, maternity, paediatric and neonatal services and had an annual turnover of £249 million in 2013/14. Across its 46-acre site, we employ just over 3,700 whole-time equivalent NHS staff.

We are proud of the services we provide and of our staff who go 'above and beyond' to do the very best they can in what can sometimes be difficult circumstances.

We have a longstanding focus on improving the quality of our services, and we set high standards for ourselves. The Trust offers a comprehensive range of acute and secondary care patient services.

Suffolk's Local Health Economy currently consists of two local clinical commissioning groups (West Suffolk CCG, Ipswich & East Suffolk CCG), Norfolk & Suffolk NHS Foundation Trust (mental health services) and West Suffolk NHS Foundation Trust (acute services) and us. All partners work to serve the Suffolk population and have built strong and cohesive working arrangements. The Local Health Economy partners work together with Suffolk County Council at the System Leaders Partnership Board and Health and Wellbeing Board.

Woodbridge Ward
Joint Winner: Team of the Year Award

Business Information including structure and management

Business Information

The Health and Social Care Act has led to major changes in the structure of how services are commissioned and will continue to be commissioned in the coming years. There have also been significant enquiries and reports published into the failings in some healthcare organisations. The Media continues with its unending interest in the NHS. There are increased calls for changes in how and where services are delivered and political complexities of how service changes can be achieved cannot be underestimated. Managing demand, safety quality and patient experience in addition to financial sustainability will be challenging to all NHS Trusts.

According to Chris Hopson, chief executive of the Foundation Trust Network:

'The next five years will be among the most challenging in the NHS's history. The service faces an unprecedented financial squeeze whilst needing to reconfigure to ensure long-term clinical and financial sustainability; move to new integrated models of care; improve quality of care and patient outcomes; and tackle long-standing health inequalities'.

The establishment of the Better Care Fund (which is a pooled budget for health and social care services shared between NHS and local authorities – it was created with the intention to deliver better outcomes and greater efficiencies through more integrated services) will potentially release more funding to innovate for services outside the hospital but also create new pressures on finding flows into acute provider organisations.

In addition to these national influences, there are local priorities that the Trust will seek to support over the coming years.

The Francis and Keogh reports

The recommendations from the Francis and Keogh reports continue to impact upon all healthcare providers and both will continue to influence public policy for the duration of this strategy. Their recommendations have led to significant changes and broadening of the inspection regime for hospitals. They have highlighted the vital role that culture plays in allowing people to speak up when they feel it is appropriate, the responsibilities that managers have in being 'fit and proper' people to lead vital services as well as ensuring that a comprehensive set of measures is in place to identify where services may be running at risk. Ensuring that organisations are:

- safe
- effective
- caring
- responsive to People's need
- well led

are at the core of the revised inspection regime. The organisation has reflected upon the findings of these key reports, and in addition to delivering the action plans we have developed in response to them, we will continue to build this learning into our Quality, Productivity and People, Development and Education Strategies. By ensuring that we have the plans in place and deliver these strategies, then we believe that our services will be rated as 'Good' or 'Outstanding' by the CQC.

Jonathan Douse, Respiratory Consultant
Highly Recommended: Leadership Award

Business Information including structure and management

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. Every hospital is monitored to make sure they continue to meet essential standards of quality and safety. Ipswich Hospital was visited by the CQC in February 2014 and was found to be meeting essential standards of quality and safety inspected with one minor concern noted about documentation for Do Not Attempt Resuscitation.

Our Vision and Values

The Trust's strategy is based on delivering quality, compassionate, sustainable patient care for the patients we serve.

Our vision is:

To be trusted by patients, their carers and our staff to provide the high quality healthcare and expertise our patients need – for themselves and those they care about.

Our services to be characterised by	Our Values
A cheerful, friendly welcome	RESPECT
Kind people who care for you	KINDNESS
To be fully involved	LISTEN & INVOLVE
To feel reassured and safe	PROFESSIONAL
An organised and efficient services	EFFICIENT
A skilled team, always improving	IMPROVING TOGETHER

To deliver this we need all those who are part of the organisation, our staff, volunteers, suppliers and those who work with us to deliver care to share our vision.

At the core of the organisation are a set of values we expect everyone to commit to. Developed with our patients and staff over the past 18 months they represent us at our best and our ambition is that these represent us every day for all our patients and colleagues.

How will we approach the next five years?

Our plan for the next five years is set against a period of an unprecedented combination of organisational change for the NHS coupled with an increasingly challenging financial climate.

We will:

- build on the opportunity that changes in commissioning arrangements represents;
- ensure the continued delivery of efficient and effective services delivered to every patient every day; and
- deliver this within the Trust's financial resources.

By doing this we place ourselves in the position to take all opportunities in the future to make a sustainable future.

In looking at the our strategic position, our short- to medium-term organisation objectives can be described in four key but not separate phases of development:

Human Resources Support Services
Nominee: Team of the Year Award

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Business Information including structure and management

Phase I (2013 / 14 and beyond): Embed a model of clinical leadership in the organisation which ensures all aspects of care are delivered – safety, quality people and financial. Central to our leadership model is the embedding of our values and during Phase 1 we will start the process of setting our values into our people processes. Our Accountability Framework includes all these elements of performance. An important component of our quality drive will be to build our reputation for the quality of the research, education and learning environment within the organisation. This will have both direct patient and employee experience benefits.

Phase II (2013 / 14 to 2015 / 16): Ensure that the services we provide are as efficient as they practically can be and work constructively with our health community to provide care in the right settings and moving care effectively between settings. This will require the continuing improvement in quality whilst reducing costs. Like all other district general hospitals we are challenged to deliver cost improvements, streamline systems and deliver quality improvements. We have identified a number of areas where our performance can improve although internal productivity alone cannot meet the financial challenge facing the organisation.

When considering our commissioners' intentions it is clear that their demand management initiatives will aim to redirect patients to other services and reduce the number of patients requiring admission to hospital. Our commissioners will also seek increased competition for less complex services from private and community and third sector providers. In the light of these intentions we must release direct and indirect costs to deliver our cost improvement challenge, increase market share particularly at the boundaries of our traditional patient geographies.

Phase III (2015 / 16 to 2016 / 18): Take the opportunities that the changing environment for delivering healthcare offers, across care settings and organisations. We have demonstrated good quality and operational performance and have the benefit of many patients and carers who are hugely proud and passionate about the success of the organisation. The new commissioning environment means that we have new partners who need to feel as confident in the capability and potential of the organisation. We will work in partnership with commissioners and providers across the local health economy to ensure that Ipswich Hospital takes a leadership position the centre of the local healthcare provider network.

Our commissioners are clear in their desire to deliver integrated care and the importance of an Integrated Care Model. The vision of integrated care is one wholly supported by the Board of IHT. It requires organisations to work effectively across boundaries and our commitment to a continuing programme of clinical leadership development reflects our belief in the value of working across clinical boundaries.

Phase IV (2016 / 18): Consolidate opportunities and build the organisation reputation and reach across our community.

Renée Ward, Woodbridge Ward
Winner: Clinician of the Year Award
Nominee: Emerging Leader Award and Innovator of the Year Award

Business Information including structure and management

As part of our strategy it is our intention to achieve Foundation Trust status as a standalone organisation. The Board of Ipswich Hospital NHS Trust believes that it is in the best interests of the patients we serve and the people we employ that we achieve this.

The Suffolk Health Economy Strategic Outcomes

Ipswich and East Suffolk Clinical Commissioning Group (IESCCG) is our major commissioner. The IESCCG is committed[1] "to ensuring a clinically and financially sustainable future for the local acute hospital, Ipswich Hospital, and to ensuring that primary, community and social care services ensure that patients are only treated in a hospital setting when this is the best place to deliver the assessment and treatment the patient needs.

[1] NHS Ipswich and East Suffolk CCG Integrated plan 2012/13– 2014/15

"The vision of the CCG is 'long and healthy lives for everyone in Ipswich and east Suffolk."

There are four strategic outcomes that have been agreed by the IESCCG, West Suffolk CCG, Suffolk County Council and Suffolk Providers. These are:

- Every child in Suffolk has the best start in life.
- Suffolk residents have access to a health environment and take responsibility for their own health and wellbeing.
- Older people in Suffolk have a good quality of life.
- People in Suffolk have the opportunity to improve their mental health and wellbeing.

In support of achieving these outcomes there are three system-wide workstreams that Ipswich Hospital contributes to. These are focussed on:

- Health and Independence
- Urgent Care
- Efficient Elective Care

Local Area Teams

Whilst our local CCG commissions many local services from IHT, NHS England commissions a number of services directly via its 27 local area teams. The local area team for East Anglia works with Clinical Commissioning Groups and providers of NHS services for the populations of Cambridgeshire, Peterborough, Suffolk and Norfolk. They commission primary care and public health services for our area, along with specialised services and health and justice services from providers in the East of England (including Essex, Hertfordshire and Bedfordshire). They are also host to the East of England Clinical Senate and Strategic Clinical Networks. As specialised services are commissioned from the local area team they are a key partner organisation for IHT.

Sheila Garwood, Pharmacy
Winner: Volunteer of the Year Award

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Business Information including structure and management

Our Quality Strategy

The decisions regarding which services are provided, where and how they are provided and ensuring that these are safe, effective, caring and responsive to people's need are core to the business of a healthcare organisation. Ensuring that these services are well led starts at the Board and an overarching priority of the Trust Board is to provide leadership in the areas of quality and patient safety.

In addition to the established Board assurance committees there is a comprehensive oversight programme that the whole board is engaged in – from informal Board visits to structured quality audits involving executive, non-executive and patient representatives. The combination of formal feedback from visits, comprehensive reporting to board as well as 'soft intelligence' are all essential components of the board's assurance processes.

The Trust has been registered with the Care Quality Commission since 2010. From both a patient experience and compliance perspective it is essential that the five standards set by the CQC are maintained on an ongoing basis.

Our Quality Strategy sets out our priorities and how we intend to achieve them and they fall into three broad objectives.

Objective One – Building a Patient Safety Culture

Vital in any healthcare environment is both a focus on patient safety and a culture where we willingly share experiences, learn from things going wrong and proactively use risk assessment and monitor improvement. Our values underpin all that we do and these very intentionally include the need to continually improve, speak up and keep our patients safe.

The Trust will operate within a well-developed governance and incident reporting procedure and promote an open, learning culture.

The Trust will aim to eliminate all avoidable harm to patients by the prevention of errors and adverse effects to patients associated with health care.

We will create a patient safety culture by:

Patient safety improvements

To identify areas for improvement in patient safety in line with emerging evidence base.

To be a high reporter of clinical incidents

Organisations with a high level of adverse incident reporting have an open and responsive culture to patient safety. We will continue to benchmark the Trust against other comparable Trusts, and make improvements to systems to improve the safety of our patients.

Implementation of effective falls reduction programme and elimination of avoidable pressure ulcers

To improve on the implementation of the Seven Simple Steps to achieve a reduction in the number of patients who fall, and reduce the number of patients who are injured as the result of a fall. To implement assessment and care to eliminate avoidable pressure ulcers, for example, care rounding.

Andy White, Volunteer – Fracture Clinic
Highly Recommended: Volunteer of the Year Award

Business Information including structure and management

Reduction and prevention of medication errors

Clearly, reducing medication errors reduces the risk of patient harm, and we will reduce errors by standardising and simplifying systems.

Minimise the rate of Healthcare Associated Infections

Patients rightly expect the healthcare environment in which they are treated to take all necessary steps to prevent them acquiring an infection. Excellent hand hygiene, MRSA screening on admission, thorough cleaning, adherence to High Impact Interventions requirements, and infection control training for staff are monitored at least monthly with results reported to the Hospital Infection Control Committee. Improved communication to the public on the importance of good hand hygiene and why this is important will assist infection control measures within the hospital.

Objective Two – Building a Clinical Effectiveness Culture

The Trust will build on our well-established culture of monitoring clinical outcomes and learning from best practice examples to improve the quality of health outcomes for our patients, as set out in the NHS Outcomes Framework and NICE Quality Standards.

We will improve clinical effectiveness by:

Clinical effectiveness improvements

We will identify areas for improvement in clinical effectiveness in line with emerging evidence base.

Guideline development, learning from audits and enquiries

Increase the profile for learning from the results of audits, enquiries and reports. Monitor clinical outcomes, for example through the use of Patient Reported Outcome Measures (PROMs) and post 30 days follow-up interventions.

Venous thromboembolism (VTE)

To meet the national 90% and local 98% target for assessing patients for venous thromboembolism.

Ensure audits are in line with organisational risks and priorities

Ensure mandatory reflection on key outcomes for consultant staff and wider clinical teams.

Further develop care for specified patient groups

Develop care for specific groups such as patients with dementia in line with national best practice.

Redesign of care pathways

Redesign of care pathways with a focus on quality and safety eg the emergency care pathway to be redesigned so that each individual patient is managed in the correct setting.

Monitor and act on benchmarked mortality and morbidity data

Continue to progress improvement in hospital standardised mortality rate and Dr Foster comparative data.

Diabetic Foot Clinic
Nominee: Team of the Year Award

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Objective Three – Building a Patient Experience Culture

Our work on the Future of Care to develop our values has great patient experience at its core. In addition to building our clinical effectiveness as above we will work with our patients to improve this experience. Our revised operating structures build in the importance of the patient 'voice' at more levels than ever before and we will look to build on this valuable experience. Our exceptional relationship with our community is reflected in the quality of our active hospital user groups (such as IHUG), and the number of volunteers and fundraisers we have. These individuals and groups keep us closer to our patients and we will continue to use them in addition to patient feedback, thanks, compliments and complaints to shape our plans.

Whilst we have an obligation to include patients, stakeholders and the public at the earliest opportunity in the review, reorganisation and planning of services, we will go further than our legal obligations to welcome feedback from all of those who experience the care we provide.

We will improve patient experience by:

Patient experience improvements

To identify areas for improvement in patient experience in line with emerging evidence base.

Develop our range of patient experience feedback routes

Feedback from patients and carers via in-house surveys and the National Patient Survey Programme. We will increase real-time monitoring of patient experience. We will continue to work in partnership with patients, the public and stakeholders to improve the patient experience.

Complaints, concerns and compliments will be addressed

There will be a programme of ward/clinical area visits by Board members. Information about the Patient Advice and Liaison Service (PALS) and the Hospital Advice and Complaints Service and how these services can be accessed; how complaints and concerns are dealt with, lessons learned and acted upon. Publication of 'You said, We did' within the hospital and on the website, and regular updates to show how improvements to quality of care have been achieved in response to patient/carer concerns and recommendations.

Optimise patient experience pathways for key groups

Through the work of the Older People Pathway Group, Children and Young People Pathway Group, through the work of the End of Life Group, as well as the various user groups whose membership includes patients, carers and community representatives.

Volunteers

We will further develop and support the services provided by volunteers through the hospital to enhance the quality of the patient experience and in support of staff.

Carly Ravenhill, Vascular Team Secretary
Nominee: Living the Values Award

Business Information including structure and management

Monitor the leadership of patient experience and quality of care

Through regular review of the Care Quality Commission (CQC) Essential Standards, using self and peer review and development of actions for improvement.

The Future of Care

We will recruit to our values and have explicit standards we expect of all staff in terms of how they treat patients, carers and their colleagues. We will support every member of staff to meet these standards and expect these standards to be consistently met.

Develop relationships between patients and professionals and increase community participation

Through pathway redesign work involving Ipswich Hospital User Group (IHUG) members, Shadow Governors and HealthWatch involvement in future planning and reconfiguration of services.

Increased staff awareness at all levels

Through improved communication of the purpose and value of IHUG and patient experience feedback in promoting the partnership between care providers and patients/carers.

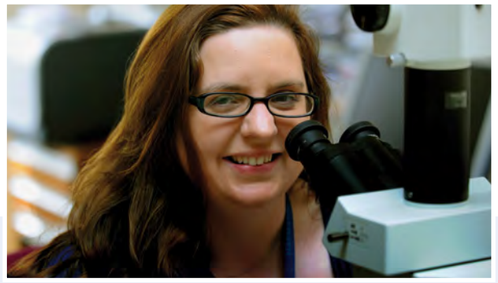
Our Clinical Services Strategy

Integrated Care

Our Commissioners have clearly identified though the publication of their commissioning intentions and five-year strategy, both the specific services they wish to tender and their more general intent to move to a more integrated model of delivery. To support this, we will work in partnership with our commissioners to develop integrated models of care that will help manage preadmission and discharge pathways from the hospital. Better integration will bring advantages for patients, for example in terms of responding to peaks and troughs in emergency demand and will also bring benefits to staff in terms of the smooth transition between care settings. Work to support a single urgent care system, integrated care and reduced emergency admissions will be vital to the sustainability of the organisation.

Specialist Services

Within the NHS there is an ever emerging picture of increasingly centralised specialist care. The NHS England 10-year strategy reinforces this broad message. The definition of specialised care and what can and should be delivered in different settings will continue to emerge over the lifetime of this strategy document. It is likely that an increased number of pathways will have elements which are delivered in specialist units. IHT will need to respond by adapting our governance structures and working practices to ensure safe and seamless integrated patient care.



Tracy Murphy, Specialty Trainee in Haematology
Highly Recommended: Trainee Doctor of the Year Award

Annual Report 2013/14

Business Information including structure and management

Given these likely changes we have identified the principles we will consider in deciding which services it is appropriate for us to build, maintain, divest, or deliver differently through, for example collaboration.

We will look to retain services in the Trust where we can evidence the quality of care and sustainability (clinically, financially and from a workforce perspective) of the service, and where clinical outcomes for patients compares well.

We will support centralisation of services where there is a clinically identified patient benefit and where services move we will work with our patients to ensure the smooth transition between providers.

Collaboration

A number of significant factors will lead to more clinical services being provided collaboratively across organisation boundaries over the coming five years.

The national drive for an increased level senior medical presence/support seven days of the week is likely to lead to an increase in shared rotas across a number of specialities. In the current financial envelope it will not be feasible to significantly increase consultant staff costs within every speciality to meet this demand and therefore changes in working arrangements will likely be combined with collaborative working across organisations.

The sustainability of services within any organisation needs to consider the workforce challenges facing the service and a number of specialties have experienced recruitment difficulties and others anticipate significant retirements over the coming years. In response to these challenges, changes in how and who delivers elements of clinical pathways need to be considered and again this may lead to increased collaboration across organisation boundaries.

Our clinical strategy can be described in three key stages:

Stage 1: 'Right size' our capacity – to support current demand and greater flexibility to respond to short-term change.

Stage 2: Sustain and improve performance – move our productivity to the levels we have identified through benchmarking.

Stage 3: Respond to local environment – use available capacity to respond to change in demand.

As part of the annual business planning cycle all clinical divisions identify growth opportunities as well as the services within their portfolio which are likely to be subject to an AQP (any qualified provider) tendering process or potentially at risk in terms of their sustainability from a quality or financial contribution perspective.

This process includes considering the quality risks associated with changing accreditation standards, capital requirements or workforce shortages. The ongoing review of which services or parts of services are provided will continue to be overseen by the Board.

Sterile Service Centre
Nominee: Team of the Year Award

Business Information including structure and management

The Trust's approach to ensuring Ipswich Hospital is well led

Following the Board's decision to introduce a revised, clinically led operating structure in April 2013, the model will continue to establish itself. Support for clinical leaders to develop in their roles will be an important focus for the Trust.

After a period of significant change the Board of the Trust has appointed an experienced executive team and non-executive members bring a breadth of experience from other sectors to the Board table. The ongoing programme of development of this team is in place in addition to activities that include the next tiers of leadership within the Trust.

Our Accountability Framework sets out our expectations in terms of quality, safety, finance, patient and staff experience for all teams within the Trust. Explicitly converting these into the expectations of individuals via the personal development plans (PDP) process is the next stage of development of the accountability framework.

The rollout of service line reporting and patient level income and costing (PLICs) will help us to make more informed decisions about service profitability and productivity. In addition it will help in decisions about the future sustainability of services and responding to commissioning intentions.

Probity and Corporate Governance

The Trust subscribes to the NHS Standards of Business Conduct and the NHS Code of Accountability, as laid out in the Hospital's Standards of Business Conduct Policy. This lays out the standards to which staff are expected to adhere in carrying out their duties.

The Trust operates a robust counter fraud strategy, and engages the services of a Local Counter Fraud Specialist (LCFS) whose role is to investigate any suspected cases of fraud, as well as to raise awareness of fraud amongst staff. Contact details for the service are published throughout the hospital.

Health and Safety Performance

The Chief Executive has overall responsibility for all matters of health and safety and for ensuring mechanisms are in place for the overall implementation, monitoring and revision of non-clinical risk policies.

The Associate Director for Estates is responsible for providing clear information about Health and Safety, Security and Fire issues to the Chief Executive and the Trust Board.

The Ipswich Hospital NHS Trust has advisors for Health and Safety, Security and Fire who report through to the Associate Director of Estates. Throughout the year the advisors have provided support and advice to the Trust managers and workforce.

Non-clinical risk is monitored and reviewed by the Trust Safety Group and the Risk Management Committee.

Progress has been made on the objectives for 2013/14 where the focus was been on training, assessment, incident reporting and action follow-up.

Work on strengthening the management of non-clinical risk was a focus for 2013/14 particularly following the restructure across the Trust. The advisors will continue to provide advice and assistance to all and guidance on how the Trust can continue to comply with its legal responsibilities and obligations.

Performance Against Key Indicators

The Trust maintained a strong performance across a range of targets, national standards and other key performance indicators including achieving 18-weeks maximum wait for patients during the year. The Trust reduced its number of hospital-acquired infections particularly C.difficile very significantly.

Key facts and figures

Births:
3,623

Emergency Department attendances:
78,804

Planned admissions:
45,787

Unplanned emergency admissions:
29,680

Outpatient attendances:
458,661

Number of appointments people did not attend:
31,150

Diagnostic Imaging examinations:
250,004

Referrals from GPs and dentists:
113,584

Emma Hardwick, Head of Midwifery
Winner: Leadership Award

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Performance Against Key Indicators

Governance Risk Ratings

Area	Ref	Indicator	Subsections	Threshold	Weighting	Historic Data: Qtr to Jun 13	Qtr to Sept 13	Qtr to Dec 13	Qtr to Mar 14
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	NO	YES	YES	NO
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	YES	YES	YES	YES
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	YES	YES	YES	YES
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	YES	YES	YES	YES
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	YES	YES	YES	YES
			Anti-cancer drug treatments	98%					
			Radiotherapy	94%					
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	YES	YES	YES	NO
			From NHS Cancer Screening Service referral	90%					
	3c	All cancers: 31-day wait from diagnosis to first treatment		96%	0.5	YES	YES	YES	YES
	3d	Cancer: 2-week wait from referral to date first seen, comprising:	All urgent referrals	93%	0.5	NO	YES	YES	YES
			For symptomatic breast patients (cancer not initially suspected)	93%					
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	YES	NO	YES	YES
Safety	4a	Clostridium difficile	Is the Trust below the de minimus	*12*	1.0	NO	NO	NO	NO
			Is the Trust below the YTD ceiling	*21*		YES	NO	YES	NO
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	YES	YES	YES	YES
			Is the Trust below the YTD ceiling	*1*		NO	YES	YES	YES
	CQC Registration								
	A	Non-Compliance with CQC Essential Standards resulting in a major impact on patients		0	2.0	NO	NO	NO	NO
	B	Non-Compliance with CQC Essential Standards resulting in enforcement action		0	4.0	NO	NO	NO	NO
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	NO	NO	NO	NO
					TOTAL	2.5	2.0	0.5	3.0
						AMBER/ RED	AMBER/ RED	GREEN	AMBER/ RED

RAG RATING	
GREEN	= Score less than 1
AMBER / GREEN	= Score greater than or equal to 1, but less than 2
AMBER / RED	= Score greater than or equal to 2, but less than 4
RED	= Score greater than or equal to 4

Operating Financial Review

2013/14 was a year of transition for Ipswich Hospital, but also the year which saw the start of its transformation into a hospital for the future.

Key target	Requirement	Result	Achieved?
Income and expenditure surplus	Break-even	£749k surplus (£50k adjusted*)	Yes
Capital cost absorption rate	3.5%	3.5%	Yes
External financing limit	Less than £2.4m	(£5.5m)	Yes
Capital resource limit	Up to £8.9m	£7.8m	Yes

* Technical accounting reporting requirements mean that the reported income and expenditure surplus has to be shown with and without the external income received from government grants and charitable funds.

The Trust reported a surplus of £749,000 after meeting all accounting and technical reporting requirements. (This year the Income and Expenditure (I&E) account included net non-recurrent costs associated with impairments of property of £333,000 and non-recurrent grants and charitable fund income net of depreciation of £1,032,000). The underlying surplus before recognising the above in year issues was £50,000.

The delivery of both a reported surplus of £749,000 and an underlying surplus is an important milestone for the Trust and evidences the positive outcome of the actions taken in 2013/14 to improve the Trust's financial resilience.

As a result the hospital met all the key financial targets again.

The Trust achieved this stronger financial position through focussing on managing activity against plan on a weekly basis and by reassessing the position against the year-end forecast with regular forward monthly financial forecasts at both Trust and Divisional level. This work was accompanied by regular Clinical Division financial meetings with a strong focus by the Project Management Office (PMO) on the Trust delivery of the full Cost Improvement Programme (CIPs).

The Trust had received £7.5m additional funding (non-recurrently) in-year reflecting the costs of maintaining emergency performance and increased costs of delivering high-quality healthcare. This included delivering recurrent savings of £14m.

Our total income rose by £14m; non-pay costs rose by £4.3m, primarily through the increased cost of drugs, and total pay costs increasing by £8.9m; the increased staffing costs are almost exclusively in medical and nursing support costs.

We ended the year with £8.5m in our bank account. The need to carefully manage cash flow during the year led to a reduction in the number of invoices paid within 30 days of receipt to 66%, down from over 90% in the previous year.

During 2013/14, the Trust also made the final repayment on its working capital loan with the Department of Health.

The Trust spent nearly £8m on improving its assets, with the key areas of investment being:

- delivery of the new Patient Administration System;
- PGME Simulation Training Suite;
- dementia ward improvements;
- Maternity refurbishment; and
- backlog and general maintenance.

2013/14 was the first full year for the hospital operating under the clinical management structure, and a significant development on our journey to deliver our vision of high quality care in a safe and compassionate environment. This vision has to be based on a strong financial strategy in order to succeed and the medium-term financial plans show that with gradually increasing surpluses, the Trust aims to move out of a cumulative deficit position before the end of the five-year planning period.

The Trust has shown that the high quality care provided in 2013/14 can be delivered within tight income streams supported by strong budget management and cost control based on the achievement of CIPs. We must also recognise the financial challenge facing all hospitals – how to deliver sustainable seven-day clinical services within an ever tightening financial envelope – a problem that is particularly pressing for hospitals of our size and geography.

It is only by continually working with our new partners in clinical commissioning groups (CCGs) that we can deliver this challenge. While the core service of our hospital remains the delivery of 24 / 7 emergency and maternity care, we need to work together to find ways to ensure the hospital remains financially and clinically sustainable.

Demand for care is growing, but the money to pay for it is reducing across the system, and that is a challenge we must all work on together if we want Ipswich Hospital to thrive.

Diane Tricker, Hostess – Capel Ward
Nominee: Support Colleague of the Year Award

Fracture Liaison Service
Nominee: Team of the Year Award

Employees

We have over 3,700 members of staff (3,174 WTE) and around 500 volunteers all working together to provide safe and caring services to our patients. There is a new structure within the hospital, enabling more clinicians to be involved in the decisions being taken and providing the direction and steer to enable the continued success of the organisation.

There are always ways in which we can improve services for patients and quality of life for our staff and we are proud to have launched the 'In Your Shoes' and 'In Our Shoes' programmes to listen to both staff and patients, enabling us to set aside dedicated time to hear stories from everyone of what their experiences have been when they have either used or provided services here.

Equality and fairness, and recognising diversity within our community and staff are always at the heart of the services we provide. Our Equal Opportunities and Diversity Policy sets out in detail how we provide equal opportunities. Our staff are actively involved in promoting health and wellbeing within the workplace, with some keen promoters of fitness volunteering to be trained as running coaches to establish for the first time 'The Ipswich Hospital Running Club', primarily aimed at newcomers to running, encouraging staff to be active, fit and look after themselves. With a sickness absence rate of 4.13% for 2013/14 we are keen to do all we can to provide support and guidance to staff on their health and wellbeing. We continue with our successful programme of health and wellbeing activities and promotional events for staff, which have been warmly received with requests for more. Below is an analysis of gender distribution for directors, senior managers and employees:

Staff Level	Gender	Head-count
Director	Female	4
	Male	4
NED	Female	1
	Male	5
Senior Level Staff	Female	86
	Male	37
Standard	Female	2788
	Male	689
Grand Total		**3614**

We continue to invest in the training and education of all our staff, and have a dedicated Education Centre on site, working closely with the local universities in East Anglia, with some of our staff teaching on programmes of higher education. Our Education Centre is used by all staff, not just clinical professionals.

Jo Wood, Human Resources
Winner: Emerging Leader Award Nominee: Living the Values Award

Key Relationships including social, community and human rights issues

Patients are at the centre of all we do. We have a strong heritage of working together with patients to make sure their voices are heard; their views shape decisions and they are active partners in planning services.

A Patient and Carer Experience Group which includes user representatives who voice the views of patients, their families and visitors, is now well-established and monitors the Trust's strategy and performance around patient experience. The key principles of our Patient Experience work are:

- All staff have a responsibility for creating an environment where patients receive a good patient experience.
- All patients and visitors should feel welcomed, informed and treated with dignity and respect throughout their patient journey.
- The environment is clean, welcoming and well furnished.
- Patients feel safe and informed about infection control measures.
- Patients receive excellent fundamental care including good food and adequate help with basic personal care.
- Patients and the public are included in the planning and evaluation of service provision and feedback that they provide (via user groups, surveys) and PALS & Complaints is used appropriately.
- Information is available for patients and carers throughout their journey, and support to understand that information is made available.
- There is adequate access to spiritual, pastoral and religious support.
- Family members' and carers' needs are considered and access to support is available.
- Bereaved family and carers have access to support.
- Patients and family/carers receive high quality 'end of life' care.
- Equality and diversity are respected at all times.

We have a well-established framework of patient representative or user groups within the hospital. The Ipswich Hospital User Group (IHUG) is the over-arching group with representation from each individual group, being full members with Suffolk Family Carers and Healthwatch as ex-officio members.

IHUG meets with the Directors and Non-Executive Directors of the hospital on a six-weekly basis allowing issues to be taken 'straight to the top' as well as enabling senior management to engage with patient and carer representatives around operational issues as well as key policy and strategy developments.

There are 14 user groups covering both specific conditions, for example, cancer and diabetes, and addressing wider issues such as disability and older people. Members are patients, carers and representatives from community partners such as Age UK. More than 150 people are actively involved in these groups and

Bereavement Team
High Recommended: Team of the Year Award

Key Relationships including social, community and human rights issues

provide insight to enable the patient and carer perspective and experience to influence the development and provision of services.

The hospital already collates patient feedback in a number of ways including asking if patients would recommend the service to their friends and family, in-house and national patient surveys, monitoring of complaints and compliments and using technology to help capture the feedback such as iPads (hand-held digital devices).

Community

We work closely with our commissioners and partners both within the NHS and local authorities (Suffolk County Council, Ipswich Borough Council, Mid Suffolk, Babergh, and Suffolk Coastal District Councils) to understand and respond to social and community issues. These include health inequalities, social inclusion, and equality of access to health services. We have a specific engagement and communications programme for communities who have traditionally not had the same level of access to health services (often referred to as 'hard to reach' groups).

Key strategic alliances

NHSLA

The NHSLA is the litigation authority which works to improve risk management practices in the NHS. Every NHS hospital is visited by independent assessors once every two to three years, and this includes visits to wards, looks at how we manage clinical risk and informs the premium we pay for clinical negligence claims. In February 2011 we were accredited at NHSLA level 2. We had previously attained level 1 accreditation so we are very pleased to have reached this higher status.

Local context

NHS Ipswich and East Suffolk Clinical Commissioning Group (the CCG) is a group of 41 GP practices in Ipswich and the eastern part of Suffolk.

Initially established in April 2012, as part of the NHS reforms, the CCG became responsible for commissioning (buying-in) and managing healthcare services following the disestablishment of the primary care trust, NHS Suffolk, on 1 April 2013.

The CCG serves a population of approximately 385,000 patients and is expected to have funding of £425m to commission healthcare services each year.

The Governing Body of the CCG comprises 13 voting members: seven GPs elected by their peers, lay members governance, patient and public involvement, accountable officer, a secondary care doctor (who has to be from out of the area) and a chief finance officer. The governing body also includes four non-voting chief officers.

As well as working closely with Clinical Commissioning Groups, the National Trust Development Agency, Local Area Team, colleague NHS trusts and local authorities, we have strategic alliances with universities and colleges, particularly University Campus Suffolk, and medical schools.

Medical Records
Nominee: Team of the Year Award

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Key Relationships including social, community and human rights issues

Serco

The Trust has been working with Serco from September 2013 on an enhanced procurement programme

Sustainability

The Trust is committed to sustainability of finite resources and has developed a proactive sustainability agenda. The Trust has developed a Carbon Reduction Plan which has been discussed and adopted by the Trust Board. The plan has also been approved by the Carbon Trust as part of the Trust's sign-up to the NHS Carbon Challenge. The Carbon Reduction Plan seeks to reduce the carbon emissions of the Trust to enable the Government carbon reduction targets to be met and addresses direct energy consumption, procurement, transport and waste. The Trust's Transport Travel Plan has been developed in conjunction with Ipswich Borough Council and this has been adopted by the Board.

The Trust will be using the Premises Assurance Model as a rigorous self-assessment tool to enable the Trust to certify that its premises achieve the required statutory and NHS nationally agreed standards.

The Trust works with our Local Strategic Partnerships and uses the Good Corporate Citizen Model to inform our decision making and support our development in Corporate Social Responsibility (CSR).

The sustainable key actions are as follows:

- The Trust has developed a Carbon Reduction Plan to achieve carbon emissions reduction in line with government national targets for the NHS.
- The Trust has calculated its carbon footprint.
- An action plan of projects has been developed to deliver the required carbon reduction targets.
- A Sustainable Development Management Plan has been introduced.
- The Trust has signed up to the Good Corporate Citizen Assessment Test and is developing an action programme based upon the results.
- The Trust carries out benchmark comparisons against similar trusts.
- The Trust will continue to work with the Carbon Trust and other sustainability/ecological organisations.

The Trust continues to seek to reduce its estate and carbon footprint where possible.

Linda Hill, Pharmacy
Nominee: Support Colleague of the Year Award

Sustainability Report

0%

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill. While our electricity consumption has risen due to site development and the installation of new equipment, the consumption of fossil fuel (gas) has fallen by 13%. Overall our carbon emissions have changed by less than 1% from last year.

£1,158,507

Potential savings

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 15 years we expect to save £1,158,507 as a result of these measures.

1305 tonnes of waste recovery

We recover or recycle 1305 tonnes of waste, which is 99% of the total waste we produce.

Our expenditure on waste in the last two years was incurred as follows:

2012/13	Clinical Waste incineration	£106,303
	Domestic Waste	£62,694
2013/14	Clinical Waste incineration	£101,860
	Domestic Waste	£66,408

Energy consumption

Our total energy consumption has risen during the year, from 24,868 to 25,501 MWh.

We supply 60% of our space heating from renewable sources; 100% of our supplied electricity is from renewable sources.

Our water consumption has increased by 4,483 cubic meters in the recent financial year. In 2013/14 we spent £297,871 on water.

CRC payment

The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. During 2013/14 our gross expenditure on the CRC Energy Efficiency Scheme was £134,292.

Design Services
Nominee: Team of the Year Award

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Sustainability Report

Sustainable Management

Our organisation is continuing to develop its Sustainable Development Management Plan (SDMP). Having an up-to-date SDMP is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

We consider the potential need to adapt the organisation's buildings and estates as a result of climate change, but not the potential need to adapt the organisation's activities. Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are included in our analysis of risks facing our organisation.

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out within our policies on sustainable procurement. We plan to start work on calculating the carbon emissions associated goods and services we procure.

The Associate Director of Estate is the Board Level Lead for Sustainability. A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Our organisation has a sustainable Transport Plan. The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Specialist Oncology Breast Care Team
Joint Winner: Team of the Year Award

Directors' Report

Composition of the Board

The overall management of the hospital is the responsibility of the Trust Board which comprises a Chair, five non-executive and executive directors.

All non-executive director appointments up to 30 September 2012 were made through the Appointments Commission. Responsibility for non-executive director appointments transferred to the NHS Trust Development Authority from 01 October 2012.

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

Membership of the Audit Committee comprises three non-executives. The Chief Executive and Director of Finance and Performance are attendees at each meeting as well as external and internal auditors.

The Committee meets five times a year. The role of the Audit Committee is to ensure effective control programmes are in place and provide an independent check upon the executive arm of the Board.

The Audit Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes. In particular, the committee's work focuses on the framework of risk control and related assurances that underpin the delivery of Trust's objectives.

The Audit Committee receives and considers reports from both internal and external auditors and reviews the annual accounts and financial statements. Through this Committee, actions are put in place to ensure that all recommendations of internal and external audit reports are picked up, as well as other assurance functions.

The Chief Executive and Executive Directors were appointed using open competition and a selection process. They were appointed on a permanent basis with exception of Clare Edmondson who was appointed on an interim basis whilst Julie Fryatt is seconded to the role of Foundation Trust Director. All are subject to annual performance reviews and all usual Trust policies and procedures. During the year 2013/14, Paul Scott was appointed as Director of Finance and Performance and joined the Trust on 3 June 2013. A substantive Chief Operating Officer Neill Moloney was appointed and joined the Trust in July 2013. Barbara Buckley, the Trust's first full-time medical director took up her post in February 2014. Clare Edmondson took up her role on 27 September 2013.

Details of directors' remuneration are given on page 37 of this report.

Chair and Non-Executives	
Ann Tate CBE	Chair
Julia Holloway*	Non-Executive Director (until 31/05/2013)
Alan Bateman	Non-Executive Director
Tony Thompson	Non-Executive Director
Andrew George	Non-Executive Director
Laurence Collins	Non-Executive Director (from 01/04/2013)
Rajan Jethwa*	Non-Executive Director (from 02/09/2013)

** From 31/05/2013 until 02/09/2013, the Trust had four non-executive directors not five.*

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Composition of the Board

Trust Executive Directors		
Nick Hulme	Chief Executive	
Rob Mallinson	Trust Medical Director	Ceased role on 02/02/2014
Barbara Buckley	Trust Medical Director	Commenced on 03/02/2014
Lynne Wigens	Director of Nursing and Quality, Infection Prevention and Control	
Mary Leadbeater	Interim Director of Finance and Performance	Until 05/06/2013
Paul Scott	Director of Finance and Performance	Commenced on 03/06/2013
Julie Fryatt*	Director of Human Resources	Became Foundation Trust Director on 27/09/2012
Clare Edmondson*	Director of Human Resources	Commenced on 27/09/2013
Margaret Blackett*	Interim Director of Transformation and Operations	Until 31/08/13
Neill Moloney	Chief Operating Officer	Commenced on 15/07/2013

** Non-voting Board member*

On 01 April 2013, a new structure for leading and managing the organisation was implemented. At the core of these changes is the intent to place clinicians in at the centre of the organisation's leadership. Within the revised structure there are three operation divisions each led by a Divisional Clinical Director supported by a Head of Nursing and a Head of Operations and an HR and Finance Business Partner. Clinical delivery groups support the Board of each division and represent all areas within the division. Corporate services provide support to all of the operational areas.

The executive directors work closely with the divisional leadership in developing strategic and operational plans. A Trustwide leadership group (the Combined Board) contributes to and implements Board, executive and clinical team decisions.

Wendy Webb, Senior Project Manager
Nominee: Innovator of the Year Award

Composition of the Board

Research and Development Strategy

The Trust's Research and Development Strategy (which also contains a policy and operational procedure for the management of intellectual property), is well established throughout the Trust. Staff working in the Research and Development office provide support and guidance to all hospital colleagues.

Governance

Clinical Governance is about continual improvement in the quality of care provided by NHS organisations, and ensuring that improvements, where needed, are made in a climate which is supportive, open and learning. The hospital has a Risk and Governance Group. Each division has a monthly Risk and Governance meeting where the groups have a vital role in bringing change, and considering clinical developments, service improvements, risk management and internal control issues throughout the Trust. The Trust complies with the clinical governance reporting framework issued in November 2002.

Emergency preparedness/ major incident planning

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

Listening and learning

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

The complaints service continues to manage the complaints process much more closely than in previous years, ensuring the process is fair, consistent and timely. Much support is being offered to Trust staff responsible for handling complaints which is welcomed. Feedback from staff, patients and relatives has generally been very good.

Complaints are recorded in three ways, depending on their severity:

High level

Multiple issues relating to a longer period of care including an event resulting in serious harm.

Dealt with by the Complaints Team.

Medium level

Several issues relating to a short period of care including, for example, failure to meet care needs, medical errors, incorrect treatment or attitude of staff or communication.

Dealt with by the Complaints Team.

Donna Barter, Fracture Clinic
Winner: Innovator of the Year Award

Annual Report 2013/14

Composition of the Board

Low level

Simple, non-complex issues including, for example, delayed or cancelled appointments, lack of cleanliness, transport problems.

Dealt with by the Complaints Team.

The complaints manager leads or reviews every medium or high level complaint investigation, checking responses and conclusions for accuracy and bias. The final response is drafted or checked by the complaints manager (often with further questioning and investigation at this point) and then passed on to the Chief Executive for final approval.

The number of complaints increased by around 14% to 709 in 2013/14 compared to the previous year (646 in 2011/12 and 619 in 2012/13). The increase is Trust-wide with no specific trends.

The PALS service continues to handle queries and concerns in a practical way, resolving and addressing issues at source to prevent issues escalating. This is a really positive step towards taking more responsibility for issues as they arise. The PALS service is now very well established and continues to see an increase in demand. 1,739 matters were handled by PALS in 2013/14. This represents a further 11% increase and follows the 28% increase in matters raised with PALS in 2012/13.

The PALS team attends wards and departments regularly to support staff in handling negative feedback from patients and relatives to encourage local resolution. As mentioned above, our PALS service allows us to monitor issues that may escalate into complaints and any issues are escalated at the time to relevant senior managers.

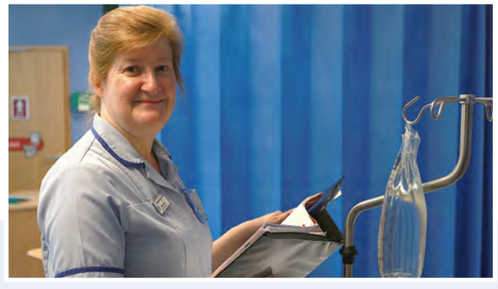
The teams welcome feedback and complaints verbally, in person or in writing and just recently we have overcome the issues surrounding email correspondence and are therefore now able to accept and respond to issues raised by email. Every complaint is acknowledged within 72 hours and a meeting is offered on request within each acknowledgment letter.

If a complainant wishes to take their complaint further we advise them they can contact the Parliamentary and Health Service Ombudsman (PHSO). In 2013/14 nine complaints were taken to the PHSO. Of these, four were closed by the PHSO without investigation, two cases were investigated by the PHSO but not upheld, one was upheld with a recommendation for compensation

The PALS and complaints service aims to not only explain and apologise when things go wrong, but work with departments to make constant improvements and adjustments following feedback.

Our work in this field is guided by the Principles for Remedy set out by the Ombudsman. These are:

1 Getting it right
2 Being customer focused
3 Being open and accountable
4 Acting fairly and proportionately
5 Putting things right
6 Seeking continuous improvement.



Karen Aylott, Haughley Ward
Joint Highly Recommended: Living the Values Award

Composition of the Board

Serious Incidents Requiring Investigation

The hospital has a Serious Clinical Incident Group which meets to discuss any untoward incident and to determine whether what has happened is a serious clinical incident, or a serious incident requiring investigation (SIRI). Both incidents are rigorously investigated. A Serious Incident Requiring Investigation is reported to both Ipswich and East Suffolk Clinical Commissioning Group and the National Trust Development Agency.

Learning from incidents

All reported incidents are investigated and any lessons that can be learnt are shared within the clinical area at Divisional Board meetings, and via the intranet for hospital areas outside the scope of the Division involved in the incident.

It is important that when serious incidents occur, they are reported and investigated, not only to ensure that the correct action can be taken, but also to ensure the Trust learns from the incident to help prevent recurrence.

The more serious incidents are categorised as Serious Incidents Requiring Investigation (SIRIs) and are reported to the Ipswich and East Suffolk Clinical Commissioning Group. These incidents are investigated, a report written and actions implemented.

In some cases, the involvement of an external investigator is preferential. This ensures those with appropriate experience investigate these cases and demonstrates openness and transparency.

The percentage of patient safety incidents resulting in severe harm or death is subject to external assurance.

Duty of candour

Following the recommendations from the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, all incidents deemed to be medium or high severity or resulting in the death of the patient are reportable to our commissioners. As part of the incident reporting process, patients or their relatives are informed of any such incidents.

Failure to meet this contracted standard results in a financial penalty. **To date, the Trust has not been subject to any penalties relating to Duty of Candour.**

What are we doing to make improvements?

- ✓ We continue to strive to ensure a high reporting.
- ✓ Held a number of training sessions to help staff with root cause analysis of incidents.
- ✓ Investigator training is available on a 1:1 basis with the Risk Management coordinator.
- ✓ We have improved the way in which lessons learnt are shared across the organisation.
- ✓ A summarised version of serious incident investigations, other than pressure ulcers and falls, are shared with staff via the risk management pages of the intranet.
- ✓ Learning from falls and pressure ulcers are available in Trustwide action plans and disseminated to each Division via the Falls Prevention Group and Pressure Ulcer Prevention and Action Group.
- ✓ A system to provide individual feedback to incident reporters on request with the aim to increase reporting is available.

Annual Report 2013/14

Composition of the Board

Our performance

Table 1 – Incidents reported

For the year 2013/14, there have been the following **incidents and near misses** (when an incident almost happens) reported on the Datix risk management computer system:

Type of incident	Incident	Near miss	Total
Access, appointment, admission, transfer, discharge	443	73	516
Abusive, violent, disruptive or self-harming behaviour	165	37	202
Accident that may result in personal injury	1743	354	2097
Anaesthesia	5	2	7
Clinical assessment (investigations, images and lab tests)	146	67	213
Consent, confidentiality or communication	124	56	180
Diagnosis, failed or delayed	28	21	49
Financial loss	1	0	1
Patient information (records, documents, test results, scans)	329	95	424
Infrastructure or resources (staffing, facilities, environment)	230	96	326
Labour or delivery	270	72	342
Medical device/equipment	172	82	254
Medication	491	232	723
Implementation of care or ongoing monitoring/review	1342	211	1553
Other – please specify in description	57	29	86
Security	58	8	66
Treatment, procedure	169	34	203
Totals	**5,773**	**1,469**	**7,242**

Of these, the following were reported as **Serious Incidents Requiring Investigation** (SIRIs):

Table 2

Type of incident	No of SIRIs
Developed pressure ulcers Grade 3 or 4	43
Unexpected neonatal death	2
Retained needle tip	1
Baby born in poor condition	5
Information governance breach	4
Unexpected death	7
Operative management	3
Management of the deteriorating patient	4
Incorrect documentation	1
Misdiagnosis (possible mismanagement of care)	1
Fracture neck of femur	12
Infection control – measles	1
Patient fall	1
Total	**85**

Examples of key changes to practice and lessons learnt following the investigation of SIRIs in 2013/14

- Surgical pathway more streamlined now Surgical Assessment Unit in place.
- Resuscitation officers have introduced the Universal Form of Treatment Options across the Trust to improve resuscitation decision making and communication with patients and their families.
- Deteriorating Patient Working Group commenced, looking at three workstreams – recognition of the deteriorating patient, escalation processes and response processes by medical staff and Critical Care.
- Introduced new Trustwide audit to review compliance against MEWS escalation policy, reported at ward level monthly.
- Reviewing every cardiac arrest and reporting cardiac arrests outside of Critical Care Unit monthly at ward level, reportable to Board.
- Critical Care Outreach Team now available 24/7.

Never Events

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

Composition of the Board

The list of Never Events from the Department of Health was updated and slightly amended for 2013/14:

1 Wrong site surgery
2 Wrong implant/prosthesis
3 Retained foreign object post-operation
4 Wrongly prepared high-risk injectable medication
5 Maladministration of a potassium-containing solution
6 Wrong route administration of chemotherapy
7 Wrong route administration of oral/enteral treatment
8 Intravenous administration of epidural medication
9 Maladministration of insulin
10 Overdose of midazolam during conscious sedation
11 Opioid overdose of an opioid-naïve patient
12 Inappropriate administration of daily oral methotrexate
13 Suicide using non-collapsible rails
14 Escape of a transferred prisoner
15 Falls from unrestricted windows
16 Entrapment in bed rails
17 Transfusion of ABO-incompatible blood components
18 Transplantation of ABO-incompatible organs as a result of error
19 Misplaced naso- or oro-gastric tubes
20 Wrong gas administered
21 Failure to monitor and respond to oxygen saturation
22 Air embolism
23 Misidentification of patients
24 Severe scalding of patients
25 Maternal death due to post-partum haemorrhage after elective Caesarean section

There are exclusions to each Never Event.

Never Events at The Ipswich Hospital NHS Trust

2011/12	2012/13	2013/14
0	1	2

Regrettably, two Never Events occurred in 2013/14. Both concerned operative management; the first was a peri-operative case involving testicular surgery and the second involved a retained needle tip. Investigations by senior clinicians took place following each incident, and areas where improvements could be made were identified and implemented. The changes implemented are regularly audited to ensure they are sustained and become embedded. Neither patient experienced any harm and both have recovered well.

Serious case review

The healthcare of two patients is being reviewed as part of a system-wide serious case review. Ipswich Hospital is contributing to this review. These cases will be ultimately peer reviewed in relation to recommendations and learning.

Safety Thermometer

The NHS Safety Thermometer is a tool for measuring patient safety, which was introduced in April 2012. The tool is used to collect information relating to some key harm factors for each patient and includes VTE, pressure ulcers, falls and urinary catheter infections. On a set day each month, every current inpatient is assessed for the presence of any of these harms and the results are recorded on a central database. This allows us to monitor the prevalence of these harms and to assess our performance in providing harm-free care.

Surgical Safety Checklist

The World Health Organisation (WHO) Surgical Safety Checklist (SSC) was developed by the World Health Organisation and incorporated into the National Patient Safety Agency alert, January 2009 for action by the NHS. The actions included ensuring the checklist is completed for every patient undergoing a surgical procedure (including under local anaesthesia).

The SSC is a paper document comprising three distinct sections 'Sign-in', 'Time-out' and 'Sign-out'. WHO encourages local adaptation of the checklist to ensure it is fit for purpose. The SSC aim is to reduce patient harm, improve teamwork and flatten hierarchy.

Composition of the Board

A WHO SSC review group comprising medical, surgical, anaesthetic and allied health professional colleagues was developed in with the main aim to review the Trust's existing systems and processes in the use and audit of the surgical safety checklist. The group meets twice a year.

Compliance at Ipswich Hospital is measured in two separate ways:

1 electronically: Theatre staff are required to complete a 'SSC checklist used' (yes or no) button on iOrmis (theatre computer system). This button has to be completed before the next screen can be accessed. This measures whether a checklist has been used for a particular patient (but it doesn't check whether all three sections of the checklist have been completed).

The compliance rate for the year is 100%.

2 paper: Recording compliance that all three sections ('Sign-in', 'Time-out' and 'Sign-out') of the SSC are completed, for all patients going through Recovery on one day per week within East, South, Blyth, Raedwald and Ophthalmic Day Care Unit theatres.

The compliance rate for the year is 99.8%.

The observational audit tool feedback concluded that the SSC is well embedded in the culture at Ipswich. Each Division has assessed the use of the checklist.

In an audit of Datix to review whether the SSC has had an impact on patient safety incidents, two cases were found which identified the WHO SSC as a key factor in identifying potential major errors prior to surgery.

Prompt Payments Code

The Prompt Payment Code is a payment initiative developed by Government with the Institute of Credit Management (ICM) to "tackle the crucial issue of late payment and help small businesses." Details of the code can be found at www.promptpaymentcode.org.uk

The code does not include any targets but is a series of principles that all NHS organisations are expected to follow during the normal course of business. The hospital has signed up to and endorsed the code.

Charging for Information

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

Needham Ward
Nominee: Team of the Year Award

Remuneration Report

Remuneration Report

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

The purpose 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;
  - the Executive Directors; and
  - other staff as determined by the Board;
- determine targets for any performance-related pay scheme contained within the policy;
- review performance and objectives of the Chief Executive and other Executive Directors;
- ensure that contractual terms of termination are fair and adhered to;
- make recommendations to the Board on the level of any additional payments contained within the policy;
- ensure that remuneration packages enable high quality staff to be recruited, trained and motivated and are within levels of affordability and are publicly defensible and amenable to audit;
- ensure the terms of reference of the Remuneration Committee are available, which should set out the Committee's delegated responsibilities and be reviewed and updated annually;

The Remuneration Committee comprises the Chair of the Trust Board, who acts as Chair, and the Non-executive Directors of the Board. At the discretion of the Chair, the Chief Executive and Director of Human Resources may be present to advise, but not for any discussions concerning their personal remuneration.

A quorum will consist of the Chair (or his/her nominated representative) and at least two Non-executive Directors (or their nominated representatives).

The Committee will meet as a minimum twice a year. Minutes are taken and a report submitted to the Board showing the basis for any recommendations.

Executive's pay is annually reviewed by the Remuneration Committee. They are presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS. Decisions to uplift salaries are based on this information, internal equity, affordability, whether there has been a significant change in a director's portfolio and thus responsibility. No executive director received a pay rise this year. Notice periods apply based on the early termination of their contract. The notice periods on resignation are as follows:

Chief Executive – six months

Executive directors – three months.

The Trust did not have a bonus scheme in operation during 2013/14.

The Trust made contributions totalling £13.6million, as per note 10.6, needed to the Pensions Agency in the year. Note 10.6 in the Trust's full accounts provides further details as to the nature of the pension scheme and accounting proactive in relation to associated liabilities. Details of the pension benefits of the Trust's senior managers are also given in the Remuneration Report. Exit packages are referred to within notes 10.4 and 10.5.

Remuneration Report

Salary and Pension Entitlements of Board Members 2013/14 (Audited)	Salary (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Bonus Payments (Bands of £5,000) £000	Benefits in Kind (Rounded to nearest £100) £00	Expense payments (taxable) total to nearest £100 £00	All pension-related benefits (bands of £2,500) £000	TOTAL (Bands of £5,000) £000
Name and title							
Nick Hulme Chief Executive	165–170	0	0	120	23	65–67.5	245–250
Paul Scott Director of Finance and Performance (06/06/2013 onwards)	110–115	0	0	1	4	127.5–130	240–245
Julie Fryatt Director of Human Resources/Foundation Trust Director	95–100	0	0	1	3	32.5–35	130–135
Clare Edmondson Director of Human Resources (27/09/2013 onwards)	45–50	0	0	0	0	5–7.5	50–55
Rob Mallinson Trust Medical Director (01/04/2013 to 02/02/2014)	25–30	205–210	10–15*	3	10	100–102.5	345–350
Barbara Buckley Trust Medical Director (03/02/2014 onwards)	20–25	0	5–10*	0	0	32.5–35	60–65
Lynne Wigens Director of Nursing and Quality	100–105	0	0	1	5	40–42.5	140–145
Neill Moloney Chief Operating Officer (15/07/2013 onwards)	85–90	0	0	0	0	50–52.5	135–140
Ann Tate Trust Chair	20–25	0	0	2	9	0	20–25
Julia Holloway Non-Executive Director (01/04/2013 to 31/05/2013)	0–5	0	0	0	0	0	0–5
Alan Bateman Non-Executive Director	5–10	0	0	1	0	0	5–10
Tony Thompson Non-Executive Director	5–10	0	0	0	3	0	5–10
Andrew George Non-Executive Director	5–10	0	0	4	0	0	5–10
Laurence Collins Non-Executive Director	5–10	0	0	0	0	0	5–10
Rajan Jethwa Non-Executive Director (02/09/2013 onwards)	0–5	0	0	1	4	0	0–5
Mary Leadbeater Interim Director of Finance and Performance (until 05/06/2013)	50–55	0	0	0	30	0	55–60
Margaret Blackett Interim Director of Transformation and Operations (01/04/2013 to 31/08/2014)	80–85	0	0	0	0	0	80–85

*Clinical Excellence Award.

Remuneration Report

Pension Benefits – Board Members 2013/14 (Audited)

Name	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2014 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2014 £000	Cash equivalent transfer value at 31 March 2013 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Nick Hulme	2.5–5	7.5–10	40–55	125–130	807	692	99	0
Julie Fryatt	0–2.5	N/A	5–10	N/A	111	87	23	0
Rob Mallinson	2.5–5	10–12.5	35–40	105–110	586	488	73	0
Mary Leadbeater*								
Paul Scott	2.5–5	12.5–15	25–30	80–85	379	285	71	0
Clare Edmondson	0–2.5	0–2.5	5–10	15–20	114	110	1	0
Margaret Blackett*								
Neill Moloney	0–2.5	2.5–5	30–35	95–100	494	447	26	0
Barbara Buckley	0–2.5	0–2.5	50–55	155–160	1026	947	9	0
Lynne Wigens	0–2.5	5–7.5	35–40	110–115	686	622	50	0

*Were not in the NHS pension scheme.

As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for non-executive members.

Maggie Ruddock, Information Technology
Nominee: Support Colleague of the Year Award

Remuneration Report

Salary and Pension Entitlements of Board Members 2012/13 (Audited)	Salary (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Bonus Payments (Bands of £5,000) £000	Benefits in Kind (Rounded to nearest £100) £00	Expense payments (taxable) total to nearest £100	All pension-related benefits (bands of £2,500)	TOTAL (Bands of £5,000)
Name and title							
Andrew Reed Chief Executive (01/04/2012 to 18/05/2012)	140–145	0	0	0	0	-22.5–-25	115–120
Julie Fryatt Director of Human Resources	95–100	0	0	0	0	25–27.5	120–125
Peter Donaldson Trust Medical Director (Tenure ended 31/03/2013)	20–25	140–145	0–5*	0	0	-27.5–-30	140–145
Stephanie (Sally) Watson Director of Finance and Performance	125–130	60–65**	0	2	7	-2.5–-5	185–190
Siobhan (Maureen) Jordan Director of Nursing and Quality (01/04/2012 to 17/06/2012)	20–25	0	0	0	0	-42.5–-45	-25–-20
Lynne Wigens Director of Nursing and Quality (13/08/2012 onwards)	60–65	0	0	0	0	65–67.5	130–135
Andy Burroughs Director of Business Development (01/04/2012 to 10/04/2012)	0–5	10–15**	0	0	0	-2.5–-5	10–15
John Watson Director of Operations (01/04/2012 to 03/02/2013)	80–85	0	0	0	0	105–107.5	185–190
Ann Tate Chair (02/04/2012 onwards)	20–25	0	0	2	6	0	20–25
Dave Norval Non-Executive Director (01/04/2012 to 31/12/2012)	0–5	0	0	0	0	0	5–10
Julia Holloway Non-Executive Director	5–10	0	0	1	0	0	5–10
Alan Bateman Non-Executive Director	5–10	0	0	0	0	0	5–10
Tony Thompson Non-Executive Director	5–10	0	0	0	0	0	5–10
Andrew George Non-Executive Director	5–10	0	0	2	0	0	5–10
Nigel Beverley Interim Chief Executive (21/05/2012 to 31/03/2013) (Paid via Ltd company and includes VAT)	195–200	0	0	0	30	0	200–205
Margaret Blackett Interim Director of Transformation and Operations (02/07/2012 onwards) (Paid via Ltd company and includes VAT)	170–175	0	0	0	113	0	180–185
Mary Leadbeater Director of Finance and Performance (24/09/2012 onwards) (Paid through an agency and includes agency fees and VAT)	150–155	0	0	0	98	0	160–165

*Clinical Excellence Award **Redundancy payment

Andrew Reed was seconded to NHS Midlands and East Strategic Health Authority and his salary was recharged to NHS Midlands and East SHA.
Stephanie Watson was seconded to NHS Midlands and East Strategic Health Authority from 17 September 2012 until 31 March 2013.

MARS: In brief, the national scheme has been commissioned by the Department of Health and developed in partnership with the Social Partnership Forum. It does not constitute a collective agreement. It is anticipated that those non-Foundation Trust employers in England that wish to run a MARS will work in partnership with their local staff-side representatives to implement this scheme.

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

Remuneration Report

Pension Benefits – Board Members 2012/13 (Audited)

Name	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2012 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2012 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2012 £000	Cash equivalent transfer value at 31 March 2011 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Andrew Reed	-2.5–0	-5–-2.5	55–60	165–170	1,150	1,082	12	0
Julie Fryatt	0–2.5	N/A	5–10	N/A	87	66	17	0
Peter Donaldson	-2.5–0	-5–-2.5	55–60	170–175	1,325	1,248	11	0
Stephanie Watson	-2.5–0	-2.5–0	35–40	105–110	674	626	15	0
Andy Burroughs	-2.5–0	N/A	0–5	N/A	46	44	-1	0
John Watson	2.5–5	12.5–15	30–35	95–100	521	414	86	0
Siobhan Jordan	-2.5–0	-7.5–-5	15–20	50–55	252	256	-18	0
Lynne Wigens	2.5–5	7.5–10	30–35	100–105	622	525	70	0

As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for non-executive members.

Off-Payroll Engagements 2013/14

	Number
Number of existing engagements as of 31 March 2014	17
Of which, the number that have existed:	
for less than 1 year at the time of reporting	10
for between 1 and 2 years at the time of reporting	3
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	4
for 4 or more years at the time of reporting	0

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	9
Number of new engagements which include contractual clauses giving The Ipswich Hospital NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	
Number for whom assurance has been requested	1
Of which:	
assurance has been received	1
assurance has not been received	---
engagements terminated as a result of assurance not being received	---

Most off-payroll engagements are made through established employment agencies and the Trust does not consider that these carry a significant risk of taxes not being properly accounted for.

Where payment is not made via such an agency, the Trust insists on a tax reference number being quoted on the invoice from the individual or service company.

The Trust will review the controls around off-payroll engagements to ensure controls are in place.

Annual Report 2013/14

Remuneration Report

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

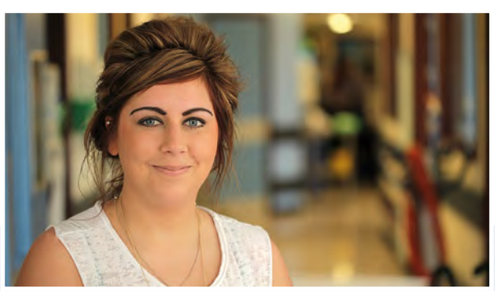
Median staff pay disclosure

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

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

The banded remuneration of the highest paid director in The Ipswich Hospital NHS Trust in the financial year 2013/14 was £246,477.47 (2012/13, £126,414.19 plus £63,000.00 MARS payment = £189,414.19). This was 9.17 times (2012/13, 6.81 or 4.55 exc MARS payment) the median remuneration of the workforce, which was £26,822 (2012/13, £27,798).

In 2013/14, 0 (2012/13, 4) employees received remuneration in excess of the highest-paid director. In the previous year their remuneration ranged from £188,884.67 – £214,103.00.



Chevelle Platt, Saxmundham Ward
Nominee: Living the Values Award

2013/14 Governance Statement

Scope of Responsibility

The Trust Board is accountable for governance and internal control in The Ipswich Hospital NHS Trust. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The Governance Framework of the Organisation

The Trust has an integrated governance approach to ensure decision making is informed by a full range of corporate, financial, clinical and information governance.

The Trust Board comprises a Chair, five non-executive director members and five executive director members: the Chief Executive, Medical Director, Director of Nursing and Quality, Director of Finance and Performance and Chief Operating Officer. Two other executive director members without voting rights attend each Trust Board meeting: the Director of Human Resources and the Foundation Trust Director. The Chair has a second and casting vote. The Trust Secretary also attends all Board meetings. A non-executive vacancy in the last quarter of 2012/2013 was filled on 1 April 2013 with a new non-executive director appointed through the Appointments Commission process under a four-year tenure. A non-executive director vacancy arose at the end of May 2013 following one of the non-executive directors stepping down. The vacancy was filled in September 2013 with a new non-executive director appointed through the new Trust Development Authority process under a four-year tenure. The Deputy Chair was appointed as Senior Independent Director in July 2013.

The executive team has stabilised during the year with substantive appointments to the three executive director posts that had been covered by interim appointments in the previous year. The Chief Executive commenced employment on 1 April 2013, the Director of Finance and Performance on 3 June 2013 and the Chief Operating Officer on 15 July 2013. The executive team was strengthened during the year by the appointment of a full-time Medical Director in support of the Trust's plans to become a clinically led organisation. The appointment of a Foundation Trust Director in November 2013 to lead the development of the Trust's strategy further strengthened the Trust's strategic focus and planning.

The Board has met on a monthly basis throughout the year with the first part of each meeting open to the public and closing as necessary for a part two confidential session. Both sections of the meeting follow a structured format with each public meeting starting with a patient or carer story to set the tone and focus of the meeting. The patient/carer story is followed by matters of quality and risk, strategy, performance and corporate governance.

In addition to the formal board meetings the Board holds seminar sessions which provide an opportunity for the Board to be briefed on a number of issues of interest or to focus on in-depth work required for strategic or other matters. During the year the Board has covered quality and risk topics including mapping board assurance processes to the Care Quality Commission monitoring and Keogh Reports, patient- and family-centred care, the Trust's quality governance framework, mortality data and board assurance framework reporting. Strategic and planning items have included sessions on the development of strategy, market share, clinical strategy and actuarial approaches and population mapping, the annual planning cycle and annual plan presentations from clinical divisions. Performance-related issues covered have included the Trust's accountability framework, service line reporting, patient level information costing, information governance and Procure 21+. In addition the Board has actively led on the development of a set of Trust Values. All Board members are actively encouraged to suggest topics for the seminar sessions.

Following discussion at a Board Development session the Board agreed to change the sequencing of its meetings held in public from monthly to bi-monthly, starting in April 2014. The new arrangements will include the opportunity to cover any urgent items on a monthly basis as required. The decision was based on agreement that the Board required regular bi-monthly opportunity to hold seminar sessions to enable more in-depth review of topics and to develop strategy. To enable greater openness and engagement with stakeholders the Chief Executive is planning to hold regular open forums in venues across the east of the county.

There is an established and robust governance framework, supported and maintained by a framework of committees. The Board has overall responsibility for the effectiveness of the governance framework and as such requires that each of its sub-committees has agreed terms of reference which describe duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness. There are six formally designated committees of the Board:

- Audit Committee
- Healthcare Governance Committee
- Finance and Performance Committee
- Remuneration and Terms of Service Committee
- Charitable Funds and Sponsorship Committee
- Foundation Trust Steering Board (time limited).

The Audit, Healthcare Governance and Finance and Performance Committees are the main assurance committees reporting to the Board. The Board receives a highlight report and unconfirmed minutes from the Audit Committee, Healthcare Governance Committee and Finance and Performance Committee at its next meeting following the committee meetings. Any amendments subsequently made to the minutes at their confirmation are reported to the next Board Meeting. The Board may request further work on various issues which are raised.

During the year responsibility for chairing the Healthcare Governance Committee and Charitable Funds and Sponsorship Committee changed following the appointment of new non-executive directors.

The Audit Committee meets on a bi-monthly basis and supports the Board by providing an independent and objective review of the governance and assurance processes upon which the Board places reliance. In this capacity as independent reviewer of the internal control environment the Audit Committee is the scrutiniser of all committees including the Healthcare Governance and Finance and Performance Committees and in this capacity receives the highlight report and minutes from those committees. The Audit Committee membership comprises three non-executive directors, one of which is

Annie Oliver, Deben Ward
Nominee: Support Colleague of the Year Award

Diabetes Centre and Information Technology
Nominee: Innovator of the Year Award

2013/14 Governance Statement

Chair of the committee. The Chief Executive, Director of Finance and Performance, Trust Secretary, Head of Internal Audit and a representative from the external auditors attend the Audit Committee meetings. Other officers of the Trust are invited to attend the Audit Committee to report on standing items such as the review of risk and also as requested on exceptional items. The Audit Committee receives assurance on fraud deterrent from regular reports from the Trust's Local Counter Fraud Group and from the Local Counter Fraud Specialist who attends the Committee at least once a year and on request.

The Healthcare Governance Committee meets on a bi-monthly basis on alternate months to the Audit Committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place to do this. The Committee has a number of reporting committees and provides assurance to the Trust Board on all matters relating to quality including patient safety, clinical effectiveness and outcomes and patient and carer experience and engagement.

The Committee has requested improvement to the way the Trust triangulates quality data in the form of a visual representation as a 'Heat Map' to clearly identify potential areas of concern. The Committee also focuses on overseeing the development of risk management activities through the Risk Management Committee.

The Healthcare Governance Committee receives assurance on the quality agenda and clinical governance activities through the Patient Safety and Clinical Effectiveness and Patient Experience Groups which report into it. The Healthcare Governance Committee is chaired by a non-executive director, and two other non-executive directors are members of the committee together with a number of the executive directors including the Director of Nursing and Quality, the Medical Director, Chief Executive, Chief Operating Officer and Director of Human Resources. The Trust Secretary attends the Healthcare Governance Committee meetings. The Head of Internal Audit also attends to mirror their attendance at the Audit Committee. During the course of the year a review was undertaken of committee attendees to enable greater participation and contribution from clinicians and the leads on quality. This has resulted in the three divisional Clinical Directors, the Heads of Nursing/Clinical Services, Head of Midwifery, Chief Pharmacist, Clinical Tutor, Patient Safety Lead and Patient and Carer Experience Lead being invited to attend the committee. Plans are also being developed for a clinical trainee to attend the committee as a learner voice representative. The committee has commenced a comprehensive review of the quality architecture in the Trust in the last quarter of 2013/14. The Healthcare Governance Committee receives the minutes of the Audit committee to ensure that there is no overlap or inadvertent omission on governance.

The purpose of the Finance and Performance Committee is to provide the Board with an independent and objective overview of finance and performance issues to assure, suggest and make recommendations to support the Board in ensuring the Trust maintains cash liquidity and remains as a going concern whilst achieving the key performance indicators assigned to it. It is held the week of the Board each month and its draft minutes are reviewed at the Board Meeting with the non-executive Chair of the Committee commencing the Board discussion on integrated performance with an overview of the Committee's discussions. This is followed by input from the executive director leads for quality, finance, national and contractual standards and organisation efficiency.

Elaine Brownlee-Pinkerton, Shotley Ward
Nominee: Support Colleague of the Year Award

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The Audit, Healthcare Governance and Finance and Performance Committees submit an annual report to the Board to review the work undertaken during the year and to set out how they have performed against their responsibilities as defined in their terms of reference. In addition the Audit Committee and Healthcare Governance committees undertake an annual self-assessment which informs the annual report. The Audit Committee's self-assessment results are discussed at the June Audit Committee meeting and the Healthcare Governance Committee self-assessment results are discussed at the May committee meeting. The committee annual reports are reviewed by the Audit Committee to inform the Annual Governance Statement. The Finance and Performance Committee has completed a full year as a non-executive-led assurance committee during the year and will undertake a self-assessment in line with those undertaken by the Audit and Healthcare Governance Committees.

The Remuneration and Terms of Service Committee is chaired by the Chair of the Trust Board and the five non-executive directors of the Trust are members. The Chief Executive and Director of Human Resources regularly attend meetings. The committee makes appropriate recommendations to the Board of Directors on the Trust's remuneration policy and the specific remuneration and terms of service of the Chief Executive, executive directors, senior management and employees employed under Ipswich Hospital's terms and conditions of service, together with other employees as determined by the Board of Directors. The committee's terms of reference have been reviewed during the last quarter of the year and a number of changes are being proposed for approval in the first quarter of 2014/15.

The Ipswich Hospital NHS Trust is the corporate trustee for charitable funds held on trust. The Trust Board serves as its agent and has delegated authority to the Charitable Funds and Sponsorship Committee to make and monitor arrangements for the control and management of the Trust's Charitable Funds in accordance with any statutory or other legal requirements, or best practice required by the Charities Commission. The Committee is chaired by a non-executive director and membership comprises a further two non-executive directors, the Director of Finance and Performance, Director of Nursing and Quality, Foundation Trust Director, Patient Group Representative and Head of Communications. The committee has undertaken a scheme of work during the course of the year to strengthen its governance arrangements which has included the development of strategy, policy and the provision of appropriate resources. The Trust Board met as corporate trustee to approve the Ipswich Hospital charitable funds annual report and accounts for the year ended 31 March 2013, to approve the Letter of Representation and to receive the ISA260 Report from the external auditors.

The Board has Standing Orders, a Schedule of Matters Reserved to the Board, Standing Financial Instructions and a Scheme of Delegation which were reviewed at the end of 2012/13 in advance of the introduction of the new organisation structure. These are currently under review and changes will be made at the end of the first quarter 2014/15 to reflect learning and new financial systems arrangements.

The Trust implemented a new divisional structure at the beginning of 2013/14. The overarching intention was to create a clinically led organisation with a single line of accountability for all aspects of performance including patient safety, patient experience, operational standards, financial performance and staff engagement. Importantly the introduction of the new structure sought to secure the engagement of clinicians including

Sarah Higson, Patient Experience Lead
Highly Recommended: Emerging Leader Award

2013/14 Governance Statement

doctors, nurses, midwives and allied healthcare professionals in the leadership of the hospital. The new structure comprised three clinical divisions to better reflect how patients come into hospital: Medicine and Therapies; Surgery; Cancer, Women and Children's Services, supported by an executive function. Each Division comprises a number of clinical sub-groups called Clinical Delivery Groups. Whilst the restructure did not significantly affect the composition or remit of the Board's assurance committees, it did result in changes to the operational management of the hospital with the creation of three Divisional Boards and a Combined Board which follow a four-weekly meeting structure as follows:

- Week 1: Divisional Board Clinical Governance and Risk Management Meeting.
- Week 2: Divisional Board Operations and Performance Meeting.
- Week 3: Divisional Board Development session for members (including patient feedback).
- Week 4: Combined Board Meeting.

Each Divisional Board is chaired by a Divisional Clinical Director who carries responsibility for the leadership of the Division. Each Division has nursing and operational leads. The Nursing Lead provides senior nursing and quality of care expertise and guidance to the Divisional Board. The Operations Leads provide expert operational advice to the Divisional Board. The Divisional Boards oversee and monitor the performance of their Clinical Delivery Groups. Whilst weeks 1 to 3 comprise separate divisional board meetings, the Combined Board meets monthly and comprises the executive team and the senior teams from the three divisional boards. The Combined Board is the senior management decision-making group of the hospital with responsibility for the implementation and delivery of the Hospital's strategic direction, business plan and associated objectives, standards and policies to ensure the delivery of safe, high quality, patient-centred care. Terms of reference for the divisional and combined boards were approved by the Trust Board. The Combined Board reports to the Trust Board on a monthly basis through a highlight report and minutes and through its members raising key issues as required. The Combined Board receives highlight reports from the Divisional Boards on key issues covered at their meetings and covers items which require escalation or further consideration by the combined group. In addition, the Combined Board reviews the accountability framework reports from each of the divisions.

An evaluation of the effectiveness of the new structure has been undertaken in the last quarter of 2013/14 and the NHS Leadership Academy was a major contributor. Feedback from the review will be used to further develop and improve the governance of the divisional structure.

Formal evaluation of the Board during its public and confidential board meeting was undertaken in July 2013 by the Trust Development Authority. The Board reviewed the feedback provided from the observation and there were no significant issues arising as the Board works to continuously evolve its practices. The Board continued to assess itself and make progress against the Board Governance Assurance Framework during the year. A board development provider was selected during the course of the year and a development session was held in December 2013. In addition to the Board Governance Framework, the Trust has continued to assess itself during the year against the Quality Governance Framework.

Diabetes Inpatient Team
Nominee: Team of the Year Award

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The Care Quality Commission conducted two visits during 2013/14. The first was a routine, unannounced visit on 4 June 2013 when five out of 21 outcomes were reviewed and the Trust was found to have two minor impact compliance areas. Namely Outcome 4: Care and welfare of people who use services (pressure area care and pressure ulcer management) and Outcome 9: Management of medicines (storage and recording of medicines). An action plan to address the issues was developed together with the establishment of weekly task-force meetings.

The second visit was on 7 January and 8 January 2014 which was a follow-up visit to review the previous non-compliance issues identified in June 2013 and included a review of the following Essential Standards:

- Outcome 2: Consent to care and treatment.
- Outcome 4: Care and welfare of people who use services.
- Outcome 9: Management of medicines.
- Outcome 14: Supporting workers.

The Trust was found to be compliant in Outcome 4 and Outcome 9; the areas of non-compliance identified in the June 2013 visit.

The January 2014 visit found one area of minor non-compliance relating to documentation of "Do Not Attempt Resuscitation" (DNAR) forms. The documentation was noted to be inconsistent with some omissions in the recording of dates and discussions with patients and family. In response a Trust-wide audit of all DNAR forms was undertaken and any discrepancies discussed with the medical staff and changes made at that point. In addition a multidisciplinary Trust-wide audit of clinical documentation to review compliance was carried out. An action plan and working group was established to lead on the changes required.

The action plans from Care Quality Commission visits are monitored by the Healthcare Governance Committee which provides assurance on progress to the Trust Board through its highlight reports.

The Risk And Control Framework

Risk assessment

As Chief Executive, I have overall responsibility and accountability for risk management and this is shared with executive directors, who along with the whole of the Trust Board are informed on risk management and governance issues through the Healthcare Governance Committee, Audit Committee and Finance and Performance Committee. The Director of Nursing and Quality is the executive director with delegated responsibility for the coordination, implementation and evaluation of risk management systems Trust-wide.

The Trust uses the National Patient Safety Agency 5X5 risk matrix to assess the likelihood and consequence of all risks on the Trust Risk Register:

Risks scoring 15 and above (strategic) migrate to the Board Assurance Framework (BAF) and thereby inform the Trust Board agenda. The following risks were reported in the Board Assurance Framework in 2013/14 and were reviewed by the Trust Board:

Ellen Farrance, Bergholt Ward
Nominee: Living the Values Award

2013/14 Governance Statement

Table 1:
5X5 Risk Matrix

Consequence score	Likelihood score: 1: Rare	2: Unlikely	3: Possible	4: Likely	5: Almost Certain
5: Catastrophic	5	10	15	20	25
4: Major	4	8	12	16	20
3: Moderate	3	6	9	12	15
2: Minor	2	4	6	8	10
1: Negligible	1	2	3	4	5

- Lack of suitable environment to provide day unit cancer services. Risk remains on the BAF.
- Pharmacy chemotherapy service at risk due to poor condition of unit exceeding capacity. Risk remains on the BAF.
- Upgrade ageing lift with associated risk of failure in Maternity block. Risk removed from BAF in June 2013.
- Financial risk of Strategic Health Authority delay in awarding contract to Transforming Pathology Partnership. Risk removed from BAF in June 2013.
- Successful Foundation Trust application. Risk included on BAF in May 2013 and removed in June 2013.
- Risk to financial sustainability of the Trust. Risk included on BAF in July 2013 and remains.
- Impact on patient care due to patient flow and capacity issues within the Trust. Risk removed from BAF in September 2013.
- Financial and reputational impact of inability to meet operational standards/key performance indicators in Emergency Department. Risk included on BAF in September 2013 and removed in January 2014.
- If there are changes to clinical commissioning which reduce activity or increase cost of provision of services this could impact on clinical/financial sustainability of a number of services or the future of the Trust as a standalone organisation. Risk included on BAF in May 2014.
- If there is no effective plan for the known reduction of junior doctor placements there is a risk to the delivery of healthcare. Risk included on BAF in May 2014.

The Risk Management Committee reviews, validates and monitors all aspects of risk reporting and assurance, and reports to the Healthcare Governance Committee.

The Trust's Risk Management Strategy states that risk management is the responsibility of all managers and staff, whatever their position within the Trust and that staff will be provided with adequate education, training and support to enable them to meet this responsibility. Managers are expected to incorporate risk management into all aspects of their work, from business planning to local induction and training of staff, and to identify the risk management training needs of all their staff, especially as new staff join and are inducted.

Lynne Liffen, Emergency Department
Nominee: Living the Values Award

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The Trust's approach to risk management has been made available to all staff and risk management information is included in Trust induction training and subsequent updates. Staff also undertake mandatory training such as manual handling, resuscitation, infection control, and fire safety and, depending on their role, additional competency training in risk management as required by the NHS Litigation Authority.

The way in which risk is identified, evaluated and controlled within the Trust is based on the following cycle:

- **Identification and reporting of risk** – Identification of the risks facing the Trust, working in a way that spreads the workload and ensures that the initial identification of risk is not too onerous;
- **Calculation of the importance of each identified risk** – Achieved by undertaking an assessment of the 'likelihood' of the risk occurring and determining the 'consequences' should the event occur, using a matrix based on the National Patient Safety Agency risk matrix;
- **Confirmation or introduction of controls and mitigating actions** – This stage of the cycle aims to confirm or introduce specific controls to deter and prevent the materialisation of identified risks. These controls (for example, policies and procedures, controls and reporting mechanisms, deterrent and disciplinary actions) will differ and be prioritised according to the severity of the risk involved;
- **Assessment of the level of residual risk** – This is the assessment of the effectiveness of the controls that are already in place and revised ones that are being implemented following the identification of a perceived risk; and
- **Review and challenge** – The Trust monitors and reviews all reported risks, using the same methodology as outlined above to ensure that controls remain effective and robust.

A register of identified risks facing the Trust is in place. This details risk issues, severity of risk, controls in place and agreed action plans. It has been developed by the identification and assessment of risks at a local level within the Trust. All principal risks are subject to a continuous process of review and validation by Divisions, and the Trust's Risk Management Committee.

Work started in 2012/13 to align risks to the three assurance committees via the NPSA domains and to the Trust's strategic objectives has continued in 2013/14. Further work to improve risk processes commenced in the fourth quarter of the year with a review of the risk management processes within the Trust. This has included a review of the Board Assurance Framework risk identification process and reporting mechanisms together with a review of the risk register carried out at Board Seminar Meetings in March and April 2014. Changes to risk reporting at Board level in the year have included the introduction of information on the operational risks scoring 15 and above.

The Trust formally investigates all serious clinical incidents (Serious Incidents Requiring Investigation – SIRIs), reports their findings via the Risk Management Committee and follows up on all actions agreed as part of the outcome of the report. The Board receives a report at each meeting on Serious Incidents, high level complaints and claims.

The Directors of the Trust are required to satisfy themselves that the Trust's annual Quality Account presents a balanced picture of the Trust's performance over the period covered and the performance information reported in the Quality Account is reliable and accurate. In doing so, we are required to put in

Theresa Hazelton, Haughley Ward
Nominee: Living the Values Award

2013/14 Governance Statement

place a system of internal controls over the collection and reporting of information included in the Quality Account. The Board has been actively involved in the preparation of the Trust's annual Quality Account and the proposed improvement priorities for the coming year. The Trust has consulted widely on its quality priorities with internal and external stakeholders, who have an opportunity to comment on the programme.

Data security

In 2013/14 the Trust achieved a satisfactory assessment at 83% for its information governance assurance under the Information Governance Toolkit.

The Trust had four data security breaches that were reported to the Information Commissioner's Office during 2013/14. In 2014/15 to date two breaches have been reported to the Information Commissioner's Office.

Three breaches related to paper-based data loss and the other three related to staff inappropriately accessing personal data. They were:

In July 2013 the Trust identified a level 3 information governance breach which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 10 July 2013 (ICO Reference Number PCB0503894). Details of medical conditions of five patients had been accessed by a member of staff with no legitimate relationship. Information has then been divulged to third parties. The patients affected were all informed by the Trust.

In November 2013 the Trust identified a level 8 information governance breach which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 25 November 2013 (ICO Reference Number ENF0521850). A redundant printer was sent to a third party for recycling. The printer tray hadn't been emptied and contained clinical paperwork of 154 patients. The patients affected were informed by the Trust.

In December 2013 the Trust identified a level 2 information governance breach which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 4 February 2014 (ICO Reference Number ENF0529590). Details of medical conditions of one patient had been accessed by members of staff with no legitimate relationship. Information has then been divulged to third parties. The patient affected was informed by the Trust.

In February 2014 the Trust identified a level 2 information governance breach which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 18 February 2014 (ICO Reference Number PCB0532006). Details of medical conditions of one patient had been accessed by members of staff with no legitimate relationship. Information has then been divulged to third parties. The patient affected was informed by the Trust.

In February 2014 the Trust identified an information governance breach (level yet to be determined) which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 2 May 2014 (ICO Reference Number COM0539980). A Child Health handover sheet relating to 21 patients was found in a hospital corridor and handed in by a member of the public.

In April 2014 the Trust identified an information governance breach (level yet to be determined) which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 15 April 2014 (ICO Reference Number COM0538295). A Neonatal Unit handover sheet relating to 20 patients was found in the street in Ipswich town centre.

Sally Talbot, Acute Medical Unit
Highly Recommended: Support Colleague of the Year Award

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The Trust maintains a robust response to incidents that occur which includes the appropriate use of human resources policies.

Actions taken to mitigate future incidents include a broadcast sent to all staff reminding them that the only records they can legitimately access are in relation to their work, all Central Bank staff are to receive information governance training at Corporate Induction. All information security incidents are graded and reported according to the Trust's Serious Incidents Requiring Investigation Policy. This enables learning to result from any incidents. The Trust's Information Management and Technology strategy is focussed on a paper-light organisation and includes the use of Lorenzo Regional Care, Evolve Mobile, scan-on-demand medical records service and managed print services. The Chief Information Officer has attended the Audit Committee to provide an overview of information and information technology assurance.

Performance against national priorities set out in the NHS Constitution 2013/14

During 2013/14 the Trust has demonstrated good performance against the key performance indicators. Key achievements this year include:

- Full year compliance at 95.83% across 2013/14 with the 95% threshold for Accident & Emergency 4-hour waits.
- Compliance across the 18-Week admitted 90.5% and non-admitted 97.9% and incomplete thresholds 97.3% across the 2013/14 reporting year at a Trust level.
- Compliance across the 2-Week, 31-Day and 62-Day Cancer Treatment targets across 2013/14 as a reporting year.
- The Trust also exceeded its C.difficile trajectory for no more than 21 cases in 2013/14 with 23 cases although three of these cases were upheld following appeal.
- The Trust did not achieve its MRSA trajectory of no more than zero cases in year, recording one case across 2013/14. The Trust also failed to achieve the 99% compliance required on diagnostic tests undertaken within six weeks due to problems across the Quarter 2 and 3 of 2013/14 achieving 97.9%.

Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. His opinion is that the overall arrangements provide satisfactory assurance that there is a generally sound system of internal control in place in the areas reviewed, and the controls are generally being applied consistently and effectively. However some areas for improvement were identified.

Only limited assurance could be provided on the controls in three areas: pharmacy stock control account reconciliation, outpatient outcomes forms and complaints. Management have taken action to resolve the pharmacy stock control account reconciliation and the outpatient outcomes forms during the year and the actions have now been completed. The audit on complaints was conducted in the last

John Decroo, Bergholt Ward
Nominee: Support Colleague of the Year Award

2013/14 Governance Statement

quarter of the year and action plans to resolve the issues raised will be addressed in 2014/15. In addition to the Head of Internal Audit opinion, the Audit Committee Chair provides the minutes together with a brief summary highlighting areas for the Board's attention following each committee meeting to the next Board Meeting in public.

During the year the Trust continued its work to ensure audit recommendations were closed down in a timely manner with the Audit Committee giving specific focus to this. Improvements in process have been made during the year with responsibility for the management of internal and external audit recommendations moving to the Finance Department and further actions have been agreed to improve the process. Every month a report is prepared by the Finance Department for the Audit Committee. The report highlights any recommendations which have passed their due date, listed by division. The report indicates new recommendations which have been closed during the reporting period. This remains an ongoing improvement priority to ensure that internal audit is embedded as a management tool.

A significant issue raised within last year's statement relating to the outcome of a Midlands and East Multiprofessional Deanery performance and quality assurance visit in March 2013 as part of a scheduled two-yearly cycle has been addressed during the course of 2013/14. The decision of the Deanery in relation to medical education and training had been met with conditions. The conditions related to patient safety issues in the Emergency Department and their relationship to training, supervision and support for Foundation trainees at night in Medicines and Surgery. A Health Education East of England action plan was put in place in April 2013 and progress was monitored by the Medical Education Forum, Strategic Education Board and the Healthcare Governance Committee and reported to the Trust Board regularly throughout the year. By the end of November 2013 the majority of the action points had been achieved with the remaining ones subjected to close scrutiny and monitoring to ensure sustainability before being rated green.

Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by comments in reports and other feedback from Internal Audit, External Audit, NHS Litigation Authority for NHS Trusts, NHS Litigation Authority for Maternity Services and internal Trust updates on progress against the action plans from various internal and external reviews of internal control and from the Care Quality Commission. I also take into consideration reviews by other external bodies including the Ipswich Hospital Users Group, the Ipswich and East Suffolk Clinical Commissioning Group, Suffolk County Council Health Scrutiny Committee, Healthwatch Suffolk, the Trust Development Authority and the Department of Health

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, Combined Board, Audit Committee, Healthcare Governance Committee, Finance and Performance Committee and Risk Management Committee as part of our approach to integrated governance. In summary, the Board reviews the Board Assurance Framework and receives minutes and highlight reports from the Audit Committee, Healthcare Governance Committee and Finance and Performance Committee. The Audit Committee reviews the underlying assurance processes and the effectiveness of the management of strategic risks. A key role of the Healthcare Governance Committee is to review action plans to mitigate risks identified. It is assisted in this role by the Risk Management Committee which identifies operational risks and ensures that local controls are in place to manage these. The executive directors and clinical divisions have a key role in managing risks, monitoring the control environment and ensuring that risks are escalated to produce a Board Assurance Framework for Board review. The internal auditors provide independent assurance on the application of governance, internal control and risk management. The external auditors provide independent assurance in respect of statutory accounts and value for money.

Annual Report 2013/14

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As a result of my review I consider the following items to be significant issues and therefore warrant further disclosure:

The external auditors have issued an unqualified opinion on the annual financial statements and a qualified value for money conclusion. The qualified conclusion is by exception and relates to securing financial resilience and economy, efficiency and effectiveness. There were two reasons for this conclusion. In respect of 2014/15 cost improvement plans (CIPs), at the time of the audit schemes had been identified to the level of £13.2m of a target of £14.3m, representing 92% of the anticipated savings needed for 2014/15. £1.1m of savings are yet to be identified, costed and quality assured. In addition the Trust has not met its statutory target to break even over a five-year period, with a cumulative deficit remaining of £3.4m.

An underlying £8m deficit was identified in Quarter 3 2013/14. As a result the Trust has declared a financial strategy to return to breakeven in 2015/16, with a planned £4.9m deficit in 2014/2015. The Trust has received £7.5m of non-recurrent commissioner support from NHS England to support the continuity of services in 2013/14.

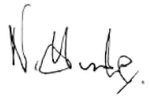
Two Never Events have been notified and investigated during the year. Never Events are classified as adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable if the available measures have been implemented by healthcare. One case involved peri-operative care for surgery (February 2014). A second case involving a retained needle tip (March 2014) has been initially classified as a Never Event and is subject to ongoing investigation. Neither case resulted in serious harm to a patient. The Trust will ensure that it implements all learning points from the investigations. Changes implemented will be regularly audited to ensure they are sustained and become embedded.

Last year's statement highlighted as a significant issue an internal audit report on the quality of consultant job plan (weekly diary plans) records that had resulted in limited assurance and a number of recommendations including one high priority recommendation that the job planning process for 2012/13 should have been fully completed by December 2012. In reviewing the job planning processes it had become clear that the proposed dates were not consistent with the scale of review, capacity planned approach and team job plan approach. Progress has been monitored throughout 2013/14 by the Audit Committee. The Medical Workforce Steering Group (MWSG) continues to meet on a monthly basis. At the meeting on 21 March 2014, the Divisional Clinical Directors and Heads of Operations were confident that job planning within their areas would be concluded by mid-April 2014. Progress updates received since this meeting have identified that further work is still required in some specialties. Whilst it is recognised that job planning discussions are ongoing, this has not yet resulted in the submission of 2013/14 job plans. A review by speciality and by consultant will be undertaken at the MWSG meeting on 23 May 2014 and an action plan developed and agreed. This will be monitored on a weekly basis by members of the MWSG.

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:



Date:
05 June 2014

Hannah English, Gynaecology Sister
Nominee: Emerging Leader Award

2013/14 Governance Statement

Head of Internal Audit Opinion on the Effectiveness of the System of Internal Control at Ipswich Hospital NHS Trust for the Year Ended 31 March 2014

Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with NHS Internal Audit Standards and Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (ie the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its AGS.

Carol Bolton, Ear, Nose and Throat Department
Highly Recommended: Support Colleague of the Year Award

Annual Report 2013/14

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The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its AGS.

My opinion is set out as follows:

1 Overall opinion;

2 Basis for the opinion;

3 Commentary.

My overall opinion is that

Satisfactory assurance can be given as there is a generally sound system of internal control in place in the areas reviewed, and the controls are generally being applied consistently and effectively. However some areas for improvement were identified.

The **basis** for forming my opinion is as follows:

1 An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2 An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

3 Any reliance that is being placed upon third party assurances.

The overall opinion level categories used by CEAC as set out on the next page, and are consistent with the assurance level categories assigned to each audit throughout the year 2012/13. These assurance levels have been developed considering the Department of Health's (DH) guidance (Gateway Approval Number: 15460) and are embedded in CEAC's quality manual. For the purposes of clarification, the overall opinion of Good would be included in the DH's definition of Significant Assurance.

The commentary below provides the context for my opinion and together with the opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes.

An Assurance Framework has been established which is designed and operating to meet the requirements of the 2013/14 AGS and to provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

The risk-based plan was constructed from the Assurance Framework and Risk Registers, essential audit coverage of fundamental systems, other areas of client concern, accumulated internal audit knowledge and experience and other risk assessment processes (audit needs assessment). The plan is monitored by the Audit Committee who have been effective in discharging their duties in accordance with the Audit Committee Handbook.

The effectiveness of the controls operating in each system examined has been rated according to the scheme set out below.

There have been no limitations of scope or coverage placed upon internal audit work during the year.

Rating	Explanation of Rating
Excellent	There is a sound system of internal control in place, and the controls are being consistently and effectively applied in all the areas reviewed.
Good	There is a generally sound system of internal control in place in the areas reviewed, and the controls are generally being applied consistently and effectively, with only minor improvements identified.
Satisfactory	There is a generally sound system of internal control in place in the areas reviewed, and the controls are generally being applied consistently and effectively. However some areas for improvement were identified.
Limited	There are weaknesses within the system of internal control, and/or key controls are not being applied consistently or effectively in the areas reviewed, which may adversely impact on the organisation.
Unacceptable	Serious weaknesses in the design and/or, inconsistent or ineffective application of controls in the areas reviewed, which may adversely impact on the organisation.

2013/14 Governance Statement

The following table (right) contains my opinion of the work carried out by Internal Audit during the year on the effectiveness of the management of those principal risks identified within the organisation's Assurance Framework. On this basis it is my opinion that for the identified principal risks covered by Internal Audit work the Board has the following assurance (see table, right):

Areas that have been reviewed by Internal Audit through the year but are not reflected in the Assurance Framework are detailed in the following table.

Audit Area	Assurance
13/14 Serco Baseline Methodology	**Advisory**

Reliance placed upon third party assurances.

Account has also been taken of the results of work carried out by the Trust's Local Counter Fraud Specialist during the year.

Name: **N Abbott**

Date: **May 2014**

Head of Internal Audit

Principal Objective	Assurance and Relevant Audit Reports
Safe, reliable, personal and responsive emergency care, planned care, maternity and children's care	**Good assurance** 13/06 Safeguarding Children 13/08 Clinical Effectiveness – Evidence-base Practice **Satisfactory** 12/09 Patient Property 12/24 Waiting List Management – ALL follow-up 13/02 CQC Essential Standards – Monitoring 13/03 Management of Records 13/04 Patient Safety – Staffing 13/16 Cancer Waiting Lists 13/17 Pharmacy – Stocks Management 13/23 Information Governance Toolkit 13/20 Network Review **Limited** 12/26 Outpatients – Outcome Forms 13/18 Complaints
Workforce Developments	**Satisfactory** 13/09 Monitoring Sickness Absence
Effective Financial Management	**Excellent** 12/23 Income **Good** 13/05 Car Park Income 13/07 Patient Finances **Satisfactory** 12/20 Procurement 13/11 Payroll 13/13 Clinical Coding 13/19 Financial systems 13/24 Capital Programme Monitoring **Limited** 13/17 Pharmacy Stock – Control Account

CEAC
internal audit, governance, risk management & consultancy

Declaration of Interests

Declaration of Interests 1 April 2013 to 31 March 2014	
Ann Tate Chair	• Governor of Rattlesden CEVC Primary School
Alan Bateman Non-executive Director	• Paid employee of Sailstone Ltd
Laurence Collins Non-executive Director (from 01/04/2013)	• Vice Chairman of Gymnastics in Ipswich • Governor of Rushmere Hall Primary School, Ipswich
Andrew George Non-executive Director	• Director of Suffolk Mind • Interest in a property syndicate (offices in Diss and Eye) • 'Independent Person' for various councils in Suffolk
Julia Holloway Non-executive Director (to 31/05/2013)	• Paid employee of Geoff Holloway, Independent Financial Advisor • Trustee – Age UK Suffolk
Rajan Jethwa Non-executive Director (from 02/09/2013)	• Chief Executive Officer of Microtest Matrices Ltd • Sole Director of the Erudite Evaluation Ltd
Tony Thompson Non-executive Director	• Paid employee in Parasol Ltd • Trustee for the Melton Trust • Elected Councillor and Chair of the Finance, Employment and Risk Management Committee of Melton Parish Council
Nick Hulme Chief Executive (From 01/04/2013)	• Nil
Margaret Blackett Interim Director of Transformation (to 23/08/2013)	• Paid employee/partner and substantial financial interest in Blackett Sharp Ltd • Member of executive committee and substantial financial interest in Britannia Sailing School Ltd
Barbara Buckley Medical Director (from 03/02/2014)	• Nil
Clare Edmondson Director of Human Resources (Part-time from 27/09/13, full-time from 01/11/2013)	• Partner – Badwell Ash Holiday Lodges
Julie Fryatt Director of Human Resources (to 31/10/2013) Foundation Trust Director (from 01/11/2103)	• Motor home rental business trading under the name Sunrise Motor Homes
Mary Leadbeater Interim Director of Finance and Performance (to 07/06/2013)	• Director of Esther Troy Ltd • Trustee of Asthma UK • Member of Asthma UK Finance and Audit Committee • Director of Caxton Foundation • Chair of Caxton Foundation Audit Committee
Rob Mallinson Medical Director (from 01/04/2013 to 02/02/2014)	• Nil
Neill Moloney Chief Operating Officer (from 15/07/13)	• Director of Casemix Ltd
Paul Scott Director of Finance and Performance (from 06/06/2103)	• Nil
Lynne Wigens Director of Nursing and Quality/ Director of Infection Prevention and Control	• Visiting Senior Fellow – University Campus Suffolk • Series Editor – Cengage Publishing (Nursing & Healthcare Texts)

Glossary of Terms

Glossary of Terms	
The Ipswich Hospital NHS Trust	• Referred to as ‘the Trust’, ‘the hospital’ or ‘we’ throughout this report.
CCG	• Clinical Commissioning Group
NHS	• National Health Service
GP	• General Practitioner
DH	• Department of Health

Sally Matthews, Saxmundham Ward
Joint Highly Recommended: Living the Values Award
Nominee: Clinician of the Year and Innovator of the Year Award

Thank You To...

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

This report was compiled by the hospital’s Communication team and designed by the Design and Print team.

Radiotherapy VERT Team
Highly Recommended: Innovator of the Year Award

Find out more about the hospital by visiting our website at www.ipswichhospital.nhs.uk or find us on Twitter: @IpsHos

Further copies of this report are available from:
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This Trust is working towards equal opportunities.

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