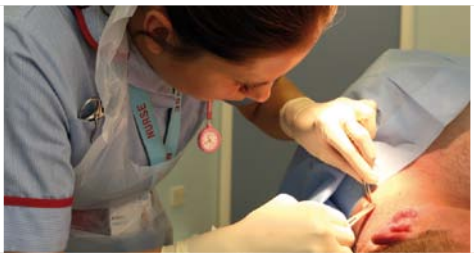
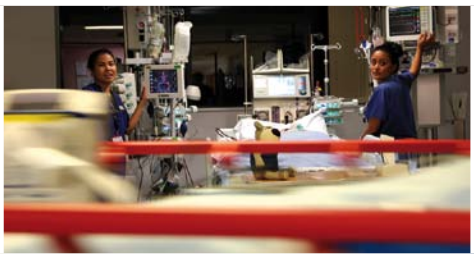
The Ipswich Hospital NHS
NHS Trust

Care Closer to You...





...Day and Night

Ipswich Hospital
Annual Report 2014/15

Our Passion, Your Care.

For our design theme this year, we have chosen to feature photographs showing our hospital activity at all times of the day and night.

Our Outpatients department handles over 545,000 appointments a year.

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

Kurdish ی.کـورد

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

Farsi ی.فـارس

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

Contents

This Annual Report has been prepared in accordance with the requirements set out in the 2014/2015 NHS Trust Manual for Accounts.

The Quality Account 2014/15 is a companion document to this report and is available online at www.ipswichhospital.nhs.uk

Welcome

Chair's Foreword

This year has seen the NHS feature more prominently in the public domain than ever before.

Obviously the election has been significant in this regard, but the community has been sensitised to a range of issues and concerns reflecting the complex pressures which the NHS has been subjected to in recent times. Whilst this hospital is by no means immune to these pressures, I am pleased to report that all our staff, from the Board to the ward, have responded in an extraordinary way to ensure continuing excellent care for our patients, whatever their needs.

It is a pivotal moment both for this hospital and for the NHS as a whole.

We welcome Simon Stephens, the new Chief Executive of NHS England bringing change with a breath of fresh air, honesty and openness.

The Ipswich Hospital NHS Trust is part of this change. We have established a solid platform of improving patient experience and quality of care for patients, cementing our rightful place in relation to high quality outcomes for our community. These outcomes have been regularly validated by external agencies and professional bodies throughout the year, culminating in our Care Quality Commission visit and report which rated the hospital overall as "Good" with outstanding outcomes in relation to emergency care.

Ann Tate CBE,
Chair.

However, we know that to ensure our long term viability and ability to continue to deliver high quality care for our community, we have to do things differently.

Much work has taken place this year by all of us at the hospital in moving to a more integrated way of providing services both in hospital and in the community.

In the pages which follow you will learn more of our strategy and our passion to deliver great care, where and when you need it.

In the weeks before Christmas, we launched a joint appeal with Macmillan, the national cancer charity, to raise several million pounds to build a new day treatment centre for cancer patients. We were able to do this thanks to the tireless and fantastic efforts of the Woolverstone Wish campaign, made up of staff working in the hospital, patients, their families and friends who raised £800,000 on their own to make this new centre possible. It is an incredible achievement. The Ipswich Hospital Charity contributed £200,000 so we had a launch platform of £1 million. We need to raise another £3.7 million. Support for the campaign has been heart- warming.

The Ipswich Hospital Charity will also be reaching out to the community with a summer cycle ride in June, visiting all the villages which our wards are named after, together with a specific campaign to make life better for very poorly babies and children in hospital.

Our community values our hospital very highly and their tangible support for our work through our fundraising campaigns is heart-warming in these days when there are so many calls upon limited resources.

My personal thanks to all of our staff, and volunteers for making this the excellent place it is to work, and to be a patient. I extend these thanks most sincerely to the community we serve, for the fantastic support you give to us, not just with fundraising campaigns, but with the trust you place in us to give you and your family the care you need, when you need it. Thank you.

Ann Tate CBE
Chair
31 March 2015

Chief Executive's Overview

This is one of the best hospitals in the country. Not my words, but those of the Secretary of State for Health Jeremy Hunt when he visited us in April 2015. His comments were prompted by our Care Quality Commission Inspection and report which rated our emergency and urgent care – outstanding, and our overall quality of care – good.

Our inspection took place in early January, during our busiest week of the year. So the achievement was quite remarkable while we also recognise that this is a not a time for complacency. The report also highlighted areas where improvement is needed and we are committed to delivering these improvements as quickly as possible.

I feel immensely proud of the team of over 3,000 staff and volunteers who every day deliver high quality, safe, compassionate care.

We are committed to improve the health and wellbeing of the local community we serve. The hospital plays an essential role in that ambition and we want to continue on our journey from being a good hospital to a great hospital.

I asked the top 100 leaders of the hospital recently whether they thought good, was good enough. The answer was no. Mediocrity is not an option.

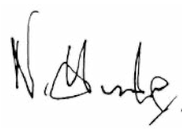
Our ambition is tempered with the reality that we need to really welcome change, to embrace the challenges all public sector organisations face in delivering more with less.

My hope is for us to become part of an integrated care organisation, with our partners including other NHS services, commissioners, and third sector organisations, to deliver seamless care for people. There should be no distinction about the standard of care people receive based on where it is delivered, at what time or what day of the week. We sum this up in our simple aim – to deliver great care, where and when you need it.

Nick Hulme,
Chief Executive.

We have begun this work with our partners and will continue this throughout the following year.

My thanks to all of our staff, volunteers, supporters and our communities for all that you do, every day, to make this hospital the special place it is.



Nick Hulme
Chief Executive
31 March 2015

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 390,000 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) to a wider population, as well as outreach services in a number of clinical specialties.

The hospital has 552 beds (as of 31 March 2015) 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.

A view across our 46-acre site.

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.

Phlebotomists head off to the wards early in the morning.

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 January 2015 and was given an overall rating as 'good' putting it in the top 30% of hospitals nationwide.

Nick Hulme, Chief Executive commented on the report saying: "We welcome this highly detailed report which finds much to praise about both the staff of the hospital and the care which is given to patients in all of the services inspected. It is a testament to each and every one of the team here in the hospital, including our staff and volunteers, that we have been rated outstanding for urgent and emergency care, and achieved a good overall rating. The report's recommendations are extremely helpful in taking us forward for the future.

"Our inspection took place in early January, which was the busiest week of the year for us, so it is with a great sense of pride that we share the inspectors' report today. The report shows that the quality of care given to children and young people is of a high standard but there is work to do in implementing recent new national guidance as soon as possible."

Mark Cubbon, Portfolio Director at the NHS Trust Development Authority said: "Staff at the Ipswich Hospital NHS Trust have worked very hard to deliver high quality care and this is an excellent result for them as well as local patients and residents, who can expect to receive good care at their hospital. We are delighted that the Trust's strong clinical leadership and innovative approaches to providing responsive and supportive care to patients have been recognised and commended. We will support the Trust as they continue to progress further improvements and sustain delivery of excellent services and care for patients, for the long-term future."

All hospitals inspected by the Care Quality Commission (CQC) are rated as Outstanding, Good, Requiring Improvement or Inadequate. As well as an overall rating, hospitals are scored in eight individual areas: urgent and emergency care (A&E), medical care, surgery, critical care, maternity and gynaecology, end of life care, outpatients and diagnostic imaging and services for children and young people.

Ipswich Hospital has been rated as good in six areas, outstanding in one (emergency care) and requiring improvement in one (services for children and young people). Actions are already underway to make improvements in the areas identified by inspectors, which include improving the service for children with complex needs and clearly defining a critical care pathway for them. The inspectors added that services for children and young people are "caring and compassionate" with "positive feedback from the majority of children and parents".

The emergency team, which boasts some of the shortest waiting times in the country, was praised for striving to improve quality care, for listening and taking time to explain care to patients and for its motivational managers.

The full report can be read here http://www.cqc.org.uk/provider/RGQ

Ambulances outside our Outpatient department.

Business Information including structure and management

Traditionally, we have provided care mainly within the hospital walls. Now, with the opportunities of modern healthcare practice and technology, we are breaking through these and other barriers to provide better care for our patients. We have new ambitions for delivering high quality, sustainable services. We are taking the organisation into a new era.

Our vision

Our vision reflects our position as a provider of healthcare for both local people and wider community. It places our patients at the core of all we do. We are committed to providing great care to all regardless of age, disability, religion, race, and gender and sexual orientation ensuring that we focus on the individual. First and foremost, trust must be felt by our patients but this also applies to our staff, volunteers and partner organisations. To deliver this vision we have identified a number of strategic objectives:

Great experience for every patient, every day – safe, effective quality care

A consistent experience for every patient, irrespective of the time of day or day of the week they use our services. This includes both the extension of services to support timely care and treatment, and the embedding of our values to ensure the consistent delivery of compassionate care. We must ensure our clinical leaders can respond to patient needs and deliver all elements of delivery – safety, effective quality care and financial balance.

Build for the future – efficiencies and integration

We will continue and extend our work to develop effective and efficient models of care, with better integration of services across organisation and geographical boundaries, and extending the services we currently provide. We will invest in key services for our patients, and review our workforce models and information technology and estate strategies to support our purpose in being a healthcare organisation.

Sustain our future – a networked healthcare organisation

Building upon our unique position in the health economy, we will use our experience to help shape future provision of healthcare, we will look to extend networked provision of care to ensure that services are sustainable both clinically and financially. We will extend our networks to strengthen educational and research links that will have a positive impact upon our patient and staff experience.

Our values mean that anyone in our care can expect:

Respect	A cheerful, friendly welcome
Kindness	Kind people who care about you
Listen and involve	Full involvement in your care
Professional	Reassurance and safety
Efficient	An organised and efficient service
Improving together	A skilled team that is always improving

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Strategic context

The Trust is progressing through its three-year journey to deliver sustainable, high-quality care through grip, people and productivity, and system redesign.

Consistency of delivery

2013/14 was a year of embedding our clinical leadership model to ensure all aspects of performance are delivered – experience, quality, people and financial – all underpinned by our robust Accountability Framework. Central to this has also been the defining and embedding of our values.

People and productivity

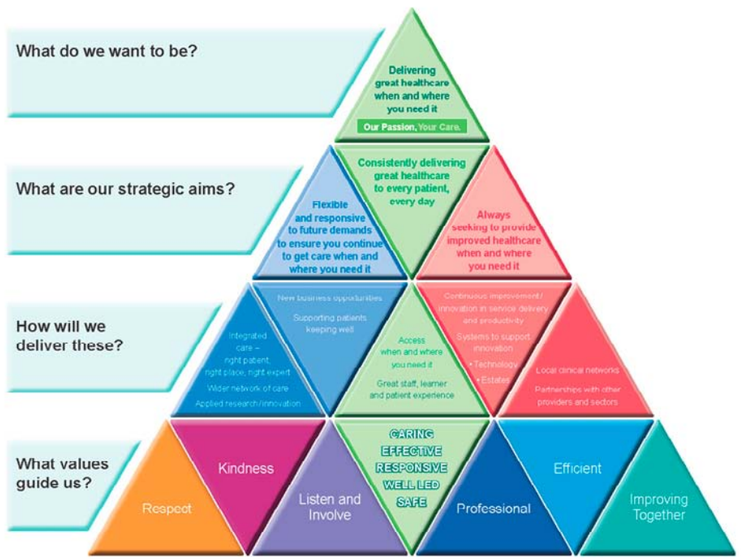
Our focus for 2014/15 was to support our people to drive up our levels of productivity and maintain operational and quality performance. To do this we enhanced the robustness of our processes and capacity to ensure we deliver our commitment to every patient every day. We also prepared for the challenges in 2015/16. We implemented an approach to talent management so that the Trust has the capacity and capability to deliver its plans. We invested in clinical information systems and developed new ways of working, brought about by supporting innovation. We also saw further benefits of our clinically led organisational structure emerge with enhanced clinical leadership and engagement across the hospital.

System redesign

2015/16 is the year when we bring to life our shared vision of an Integrated Care Model, with the opportunities that the current Community Services tender brings, underpinned by productive people and an estate that is increasingly efficient and user friendly. Delivering care at the right time in the right setting and with the right expertise is essential from both a patient and health economy perspective. As well as extending and redesigning our own clinical pathways, we will also contribute actively to work across our health economy urgent care, health and independence, and clinical networks. We will work with a broad range of providers, including the voluntary sector to provide services and support self-care for those with long-term conditions.

Consolidation

Throughout 2016/17 to 2018/19 we will need to embed the changes we have made during preceding years as these new models of care will need constant review to ensure they continue to meet the needs of patients and continue to support a sustainable health economy. In addition we will continue to build on our networks – clinical, education and research, and review services that we can deliver to the wider population.



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Strategic summary

National priorities

The Forward View into Action planning guidance outlines a number of priorities for a range of providers:

- **Financial sustainability** – the funding pressures in the NHS are reflected in around 80% of acute trusts being in deficit, and Ipswich is no exception. Transformation and new models of care are necessary to bridge the financial gap.
- **Improved system resilience** – delivering Constitution standards and increasing seven-day working. No additional in-year funding will be made available to support seasonal demand variations and these must be accommodated within baseline plans. However there is an expectation that clear additional limits on additional unplanned activity must be agreed before local mitigating action is taken.
- **End of life care** – adoption of the approach to care set out in *One Chance to Get it Right*.
- **Complaints handling** – adoption of recommendations in the CQC's Complaints Matter report, Department of Health's forthcoming *One Year On* report, and the *Freedom to Speak Up* review led by Sir Robert Francis QC.
- **Safety improvements** – continued focus on medicines optimisation and infection prevention and control, as well as improved mortality governance. This is supported by CQUINs focusing on the two main causes of premature deaths: acute kidney injury and sepsis.

Ipswich Hospital has already made progress with a number of these initiatives and is well placed to meet the national requirements.

The Suffolk Health Economy Strategic Outcomes

Ipswich and East Suffolk Clinical Commissioning Group (IESCCG) is our major commissioner.

Led by clinicians, it buys and manages healthcare services for around 385,000 people in its area, and it expects a budget of £480m in 2015/16. There are 40 member practices in the CCG, made up of four localities: Suffolk Brett Stour; Commissioning Ideals Alliance; Deben Health Group; and Ipswich.

The CCG's vision is: "Long and healthy lives for everyone in Ipswich and east Suffolk"

Its priorities are:

- to improve health and educational attainment for children and young people;
- to improve outcomes for patients with diabetes to above national averages;
- to improve care for frail elderly individuals;
- to improve access to mental health services including access to crisis care;
- to allow patients to die with dignity and compassion and choose their place of death.

It is a member of the Suffolk Health and Wellbeing Board, which encourages integrated working between the CCGH, West Suffolk CCG, Suffolk County Council and Suffolk providers.

The Health and Wellbeing strategy has the following priorities:

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

During 2014, the local health and care system worked in partnership to conduct a Health and Care Review, the key themes of which are captured in the Suffolk Five Year Plan. This work included Ipswich Hospital NHS Trust (IHT), CCGs, local healthcare providers, Suffolk County Council, care services, district and borough

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councils, and voluntary sector and communities. The plan focuses on three key areas for delivery:

- a national drive looking for integrated health and care which saves money and improves outcome and experiences for local people;
- a wish to work better together locally across the health and care system to ensure that we make best use of resources and minimise the impact of savings on patient care;
- to take full advantage of the potential of partnership working to prevent need and an increase in people's dependence.

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.

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 needs 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.

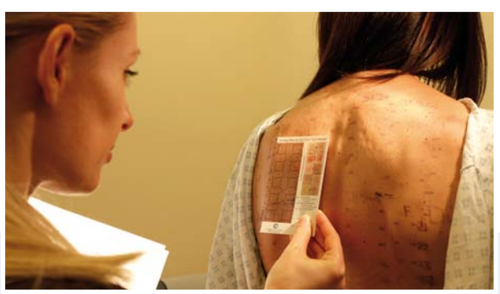
Our Quality Strategy sets out our priorities and how we intend to achieve them and they fall into three broad objectives.

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 healthcare.



Allergy testing in Dermatology.

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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.

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.

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

Business Information including structure and management

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 throughout the hospital to enhance the quality of the patient experience and in support of staff.

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.

Inside Voluntary Services.

Annual Report 2014/15

Business Information including structure and management

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.

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.

X-ray equipment in Diagnostic Imaging.

Business Information including structure and management

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.

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 2014/15 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 2014/15 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:
3,710

Emergency Department attendances:
80,698 (total)
79,647 (unplanned)

Planned admissions:
48,582

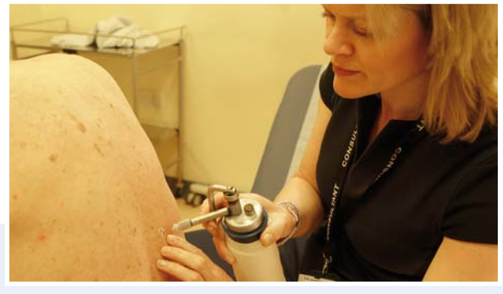
Unplanned emergency admissions:
32,135 (excluding maternity)
32,815 (including maternity)

Outpatient attendances:
545,020 (total)
518,814 (we got paid for!)

Number of appointments people did not attend:
32,344

Diagnostic Imaging examinations:
233,782

Referrals from GPs and dentists:
166,797



One of our Outpatient services – Dermatology.

Performance Against Key Indicators

Governance Risk Ratings

Area	Ref	Indicator	Subsections	Threshold	Historic Data: Qtr to Jun 14	Qtr to Sept 14	Qtr to Dec 14	Qtr to Mar 15
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	YES	NO	NO	YES
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	YES	YES	NO	YES
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	YES	YES	YES	YES
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	YES	YES	YES	YES
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	YES	YES	YES	NO
			Anti-cancer drug treatments	98%				
			Radiotherapy	94%				
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	YES	YES	YES	YES
			From NHS Cancer Screening Service referral	90%				
	3c	All cancers: 31-day wait from diagnosis to first treatment		96%	YES	YES	YES	YES
	3d	Cancer: 2-week wait from referral to date first seen, comprising:	All urgent referrals	93%	YES	YES	YES	YES
			For symptomatic breast patients (cancer not initially suspected)	93%				
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	YES	YES	YES	YES
Safety	4a	Clostridium difficile	Is the Trust below the de minimus	*12*	YES	YES	NO	NO
			Is the Trust below the YTD ceiling	*23*	YES	YES	YES	NO
	4b	MRSA	Is the Trust below the de minimus	*6*	YES	YES	YES	YES
			Is the Trust below the YTD ceiling	*0*	YES	YES	YES	NO

Operating Financial Review

The Trust reported a deficit of £11.2m in 2014/15. This includes non-recurrent costs associated with a reversal to impairments of property and non-recurrent grants and charitable fund income net of depreciation. The underlying deficit before recognising the above was £11.9m.

In previous years, the Trust (as with many NHS organisations) had been in receipt of non-recurrent income to support delivery of service; in 2013/14, this was a sum of £7.5m. In 2014/15 no additional non-recurrent support has been received by the Trust.

The Trust ended 2014/15 £7.0m away from a planned deficit for the year of £4.9m, reflecting the additional costs incurred in delivering increased non-elective care and the consequential impact on theatre productivity planned to deliver recurrent efficiencies. The Trust was one of the few organisations nationally to achieve the 95% A&E target and has been rated as Good by the recent CQC inspection.

The Trust has focused on stronger financial management throughout the organisation which, despite the financial deficit reported, has been evident in delivery of planned efficiencies of £14.0m in-year and £14.3m recurrently through the Cost Improvement Programmes (CIPs).

Total income (excluding £7.5m non-recurrent income received in 2013/14) rose by £8.7m, reflecting the increased volume of care provided by the hospital in the year.

Total pay increased by £3.1 m, reflecting the additional premium costs of medical and nursing staff to deliver the required quality (and volume) of care through the organisation. Total non-pay increased by £10.5m, with a large proportion relating to increased cost of drugs and the costs relating to the new Transforming Pathology Partnership.

At year end, the Trust had £0.1m cash in the bank account, a sum reflecting the tight financial management required given the financial position; the Trust successfully applied for £7.0m cash support, by way of public dividend from the Department of Health, in 2014/15 and will require further cash support into 2015/16. Despite this, an acceptable level of delivery against the 30-day performance target was maintained across the year at over 80%.

The Trust invested £11.8m on its asset base in 2014/15; the most notable achievement was securing significant inward investment from a national charity, Macmillan Cancer Care, to develop the oncology suite and transform provision of cancer care within the organisation; this project is underway and will complete in late 2015/16.

Other key investments in 2014/15 included:

- aseptic Unit (drug preparation area for chemotherapy);
- improvement to Saxmundham Ward for provision of dementia care;
- scope decontamination unit;
- third linear accelerator;
- £1.9m on IT improvements supporting patient care;
- £1.6m on equipment;
- £1.9m on estates improvements.

The Trust is forecasting a £19.8m deficit in 2015/16. This has been reviewed with our regulators, The Trust Development Authority, who have indicated that this plan is acceptable. The plan incorporates a requirement for cash support which the Trust expects to be in the form of Public Dividend Capital. The Trust has a short term working capital facility to support this position and will prepare, with the Trust Development Authority, an application for further cash injection via Public Dividend Capital to support the deficit plan. The Trust Board has reviewed this position and believe it to be an appropriate plan at this stage in the Trust's development. The Board is monitoring the progress with the cash application and is overseeing the development of a longer term sustainable plan.

Employees

The security and safety of our staff, patients and visitors is extremely important to us.

We have over 3,700 members of staff and around 500 volunteers all working together to provide safe and caring services to our patients. Our clinically led structure within the hospital, enables more clinicians to be involved in the decisions being taken and provide the direction and steer to enable the continued success of the organisation.

Leadership Development and Talent Management

We are strongly committed to developing our leaders. A new leadership development and talent management framework is being developed to ensure that we attract, assess and manage our leaders and offer appropriate opportunities through both local and national leadership programmes.

A talent management 'lite' pilot was undertaken during 2014/15, based on the Healthcare Leadership Model. It was recognised that this would be valuable for a number of reasons:

- to enable successful delivery of the organisational strategy;
- to identify latent and emerging talent;
- to improve succession planning through a more proactive and risk-based approach; and
- to inform development and training needs.

One colleague is now accredited and registered as a Healthcare Leadership Model 360° feedback facilitator with the Leadership Academy. This 360° tool supports leaders and managers to understand their own awareness of how their performance is viewed by their colleagues and how it compares with their own view of their performance.

Approximately 40–50 colleagues have successfully completed or are currently participating in the NHS Leadership Academy programmes, including the popular Mary Seacole, Elizabeth Garrett Anderson and Nye Bevan courses.

Ipswich Hospital recognises the vital role that first line managers play in the organisation and has continued to support first line managers by providing opportunities in house through the delivery of 'Leading an Empowered Organisation' and the 'First Line Managers' courses.

We have continued to support individual colleagues and teams through tailored leadership development courses during 2014/15.

Two very successful leadership conferences were held during 2014/15. This was a great opportunity for the top 100 clinical and non-clinical senior leaders to come together and focus on the key organisational priorities.

Weekly leadership briefings are also held every Tuesday morning with Executive colleagues.

Employees

Learning and Development

The corporate induction programme has been reviewed to ensure that it inspires and engages new starters, trainees and volunteers alike to belong to and have a sense of pride in our organisation. The review has also incorporated a complete overview of statutory, mandatory and refresher training which will ensure that we create a positive and inspiring learning experience to existing staff, enabling them to possess the required knowledge and skills to provide safe, effective and high quality care to our patients.

The changes made to the corporate induction have been measured over the last few months, and there has been a significant jump in attendees rating induction as either 'good' or 'great'.

Here are a couple of comments from new starters who recently attended their induction programme:

"I thought the emphasis on the Trust's values worked well and gives you a sense of pride working here."

"The first three talks have given me confidence to tackle a problem I encountered with patient care, on a ward, in my first week."

The Trust has been delighted to join the NHS Online Mentoring Project this year, with colleagues trained to provide mentoring support to students and young people aged 18 to 24 who are not in education, employment or training. Our involvement in this work was recognised through an article that appeared in a national newspaper.

Our journey from good to great

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

- a place to receive treatment and be cared for;
- a place to work;
- a place to be trained.

To help us to achieve this, a staff engagement and experience strategy called Building Pride has been developed which has our values at its core. This focuses on the following eight key programmes:

- Supporting staff to do the right thing
- Saying thank you for your efforts
- Keeping each other informed
- Building our future talent and leaders
- Being valued and supported
- Creating Team Ipswich
- Giving you and your team the skills to do a great job
- Looking after your health and wellbeing

This strategy is closely aligned to the NHS pledges as outlined in the NHS constitution to ensure that all staff feel trusted, actively listened to, provided with meaningful feedback, treated with respect at work, have the tools, training and support to deliver compassionate care, and are provided with opportunities to develop and progress.

Interpreting scans.

Employees

Our values and behaviours

Securing the commitment of all of our staff to our Trust values and behaviours has remained a key focus for us. We have started to apply these throughout our 'people processes' which will result in a tangible shift in our culture and will have a positive impact on achieving our objectives. Almost 100 frontline and support staff were involved in four workshops to identify the content for a range of tools and approaches that can be used to help staff make judgements and have conversations about what values-led care looks like in different situations.

A review of corporate learning and development commenced in the autumn of 2014 and has focused on making improvements in three specific areas; corporate induction, mandatory and statutory training and refresher training for clinical staff.

Two leadership conferences were held 2014/15, attended by approximately 100 senior leaders in the organisation at each event. We were delighted that we had a number of colleagues successfully complete one of the NHS Leadership Academy's national leadership programmes.

The first Schwartz round was held at the hospital in March 2015. Schwartz rounds are confidential meetings among professionals. At each meeting, three or four staff members present a story about a particular patient or topic which leads to a discussion with the audience. The premise is that the compassion shown by staff can make all the difference to a patient's experience of care, but to provide care with compassion, staff must themselves feel supported.

National NHS Staff Survey

The 2014 national NHS Staff Survey, which involved 287 NHS organisations in England, took place during quarter 3. A survey was sent to a random selection of 850 staff at Ipswich Hospital and a total of 419 colleagues responded. This resulted in a local response rate of 51% which was in the highest 20% of acute trusts in England (compared to a national response rate of 42%).

Key Findings

Overall, the questions that form the national Staff Friends and Family Test (FFT) – recommendation as a place to work or receive treatment – showed an improvement from the 2013 survey, increasing by 4.6% from 3.52 to 3.68 (1 being poorly engaged staff to 5 being highly engaged staff). Responses to all four component questions within the FFT test increased significantly:

- 'Care of patients/service users is my organisation's top priority' increased by 12%;
- 'My organisation acts on concerns raised by patients/service users' increased by 7%;
- 'I would recommend my organisation as a place to work' increased by 10%; and
- 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation' increased by 4%.

Open to all for quiet contemplation – the Hospital Chapel.

Annual Report 2014/15

Employees

The overall indicator of staff engagement increased from 3.68 to 3.75, which is in line with the national average.

The results are very encouraging and show that of the 29 key findings in the survey, the Trust improved in 16 areas and remained neutral in four. In 18 key findings, Ipswich was better or equal to the national 2014 average for acute trusts. In 2014, four key findings were in the worse 20% for acute trusts – this was a significant improvement from 2013 when 11 key findings were in this category.

The reports are available at:

Full report:

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RGQ_full.pdf

Summary report:

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RGQ_sum.pdf

The NHS Constitution outlines the principles and values of the NHS in England including four pledges that set out what staff should expect from NHS employers. The pledges are part of the commitment of the NHS to provide high-quality working environments for staff.

We provide 24-hour care for all ages.

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 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).

Annual Report 2014/15

Key Relationships including social, community and human rights issues

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.

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.

Sustainability Report

5%

NHS Carbon Reduction Strategy

The NHS was required to reduce its emissions by 10% by 2015 based on 2007 baseline data and 34% against a 1990 baseline.

These targets were reinforced by the Sustainable Development Strategy 2014–2020.

Despite a 67% reduction in emissions from gas, a 14% increase in electrical demand we achieved a 5% reduction against the 2007 baseline.

However, we achieved a 25% reduction against the 1990 baseline and have plans in place to comfortably exceed the 34% 2020 target.

£1,283,000

Potential savings

One particularly innovative project will generate electricity to the site using waste vegetable oil as the fuel source. The fuel is categorized as zero carbon and will reduce emissions, but it will also mean a saving in cost of over £1.25m per annum by 2025.

Waste

100% of our clinical waste is incinerated on site and the heat recovered is used to heat the hospital, saving on gas consumption and cost. This reduces our carbon emissions by more than 1,100 tonnes.

Our non-clinical waste is segregated and the volume sent to landfill is minimised.

Energy consumption

Our total energy consumption has been reduced by 8% during the year from 28,115 MWh to 25,969 MWh.

We supply over 60% of our space heating from renewable sources and our electricity supplier obtains all supplies from renewable sources.

Our water consumption has risen slightly by 463 cubic metres this year, and we spent £302,395 on water and sewerage.

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. The cost of CRC will increase for the next payment for 2014/15 from £12 per tonne to £16 per tonne. The payment will be approximately £176,000.

Fresh, flavoursome food is prepared in our kitchens.

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.

Chair and Non-executives	
Ann Tate CBE	Chair
Alan Bateman	Non-executive Director
Tony Thompson	Non-executive Director
Andrew George	Non-executive Director
Laurence Collins	Non-executive Director
Rajan Jethwa	Non-executive Director

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

The Chief Executive and Executive Directors were appointed using open competition and a selection process. They were appointed on a permanent basis 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.

Other assurance committees of the Board are Finance & Performance, Healthcare Governance, Remuneration and Terms of Service and Charitable Funds.

Details of directors' remuneration are given on page 35 of this report.

On-site electro-medical engineers repair medical devices.

Composition of the Board

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.

Trust Executive Directors	
Nick Hulme	Chief Executive
Barbara Buckley	Trust Medical Director
Lynne Wigens	Director of Nursing and Quality, Infection Prevention and Control
Paul Scott	Director of Finance and Performance
Julie Fryatt*	Director of Foundation Trust
Clare Edmondson*	Director of Human Resources
Neill Moloney	Chief Operating Officer

** Non-voting Board member*

Returning to a ward.

Directors' Report

Research and Development Strategy

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

Governance

Clinical Governance is about continual improvement in the quality of care provided by NHS organisations, and ensuring that improvements, where needed, are made in a climate which is supportive, open and learning. The hospital has a 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. An updated complaints policy was implemented in October 2014 placing greater emphasis on Divisional accountability for complaints. Within 24 hours of a complaint being logged by the Complaints team, a courtesy call is made to the complainant by a senior manager from the appropriate Division. This telephone call offers the opportunity to apologise and allows for clarification of the issues raised which in turn ensures our response addresses the complainant's concerns appropriately. Response letters are reviewed by the Divisional Head of Nursing or a senior manager to ensure accuracy of the content and that the appropriate investigation has been undertaken.

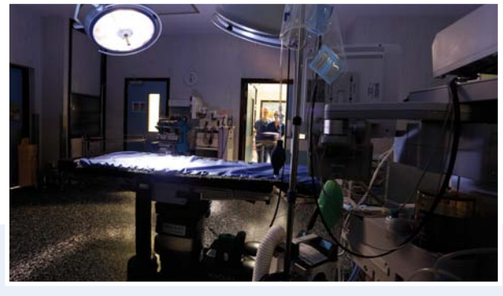
Complaints are recorded in three ways, depending on their severity:

High level – Multiple issues relating to a longer period of care including, for example, an event resulting in serious harm.

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.

Low level – Simple, non-complex issues including, for example, delayed or cancelled appointments, lack of cleanliness.

All high and medium level complaint responses are signed



Preparing one of the operating theatres.

by the Chief Executive. Low level complaints can be resolved by a telephone conversation with the relevant manager. When a written response is required to a low level complaint the letters are generally signed by the Complaint Service manager.

The number of complaints decreased by around 5% to 677 in 2014/15 compared to the previous year (709 in 2013/14 and 619 in 2012/13). The most notable decrease has been 40% fewer complaints about the Emergency Department and the Emergency Assessment Unit.

The Patient Advice and Liaison Service (PALS) continues to handle queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. This is a really positive step towards taking more responsibility for issues as they arise. PALS is now well established and continues to see an increase in demand. 2,238 matters were handled by PALS in 2014/15. This represents a 29% increase when compared with 2013/14 and follows an 11% increase in 2013/14 and a 28% increase in 2012/13.

The PALS team attends wards and departments regularly to support staff in handling negative feedback from patients and relatives to encourage prompt local resolution. Trends identified through PALS are highlighted to senior managers to enable changes to be made if necessary.

The PALS and Complains teams welcome feedback and complaints verbally, in person, in writing and also by email. In addition to the 24 hours courtesy call mentioned earlier, every complaint is acknowledged within three working days and a meeting is offered on request in the acknowledgement letter.

If a complainant wishes to take their complaint further we advise them they can contact the Parliamentary and Health Service Ombudsman (PHSO). In 2014/15, 14 complaints were taken to the Ombudsman compared with nine in 2013/14. This is in line with advice from the PHSO that they would be investigating more cases nationwide. Of the 14 cases referred in 2014/15, two cases were investigated by the PHSO but not upheld and two were upheld with recommendations for compensation. We are still awaiting the findings of the other 10 cases currently with the Ombudsman.

The PALS and Complaints services aim 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 of 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

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 SIRI 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 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. The detailed definition for this performance indicator is presented on page 34.

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

- An external Human Factors expert trained 28 staff to become investigating officers to investigate all serious incidents.
- Targeted work around never events and safer surgery.
- Introduction of After Action Reviews (AARs).

After Action Reviews

An AAR is a short, structured meeting held immediately after a short-term activity such as a clinical incident. A facilitated 'debrief', all the team members who were involved in the 'action' should participate in the After Action Review.

- An After Action Review is a short debrief, held immediately after an event has taken place (be it a successful or unsuccessful endeavour) that enables those involved to learn from what happened and change their behaviour for the future.
- The AAR comprises a structured set of questions, and a mindset of openness and thoughtfulness that is challenging but not confrontational.
- After each AAR, the participants are encouraged to write up their discussion and store it on the Trust's intranet.
- This database of AARs will build into a very valuable collection of learning outcomes.
- Although some issues appear to be negative, the fact that they are being discussed openly and learnt from is enormously positive.
  - What was supposed to happen?
  - What actually happened? (What went well, could have been better?)
  - Why was there a difference? (What caused the results?)
  - What can we learn from this? (What actions can be taken to improve or sustain what went well?)

The Medical Records department is staffed day and night.

Directors' Report

Examples of key changes to practice and lessons learnt following the investigation of SIRIs in 2014/15

- Introduction of NerveCentre to support timely escalation of the deteriorating patient.
- Radiologist review of fractured neck of femur cases.
- Professional standards launched for patients requiring admission to Critical Care Unit.
- Ensure senior review of chest X-rays for placement of naso-gastric tubes is undertaken and implement methods for improving junior doctors' competence of chest X-ray interpretation. Revised policy to include a section stating that if the chest X-ray was rotated, the naso-gastric feed not to be started until review by senior doctor or radiologist.
- Reinforce the guidance for anticipation of neonatal problems by having the correct personnel present at delivery.

Never Events

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

The list of Never Events from the Department of Health was updated and slightly amended for 2014/15:

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

Maternity reception is always open.

Directors' Report

Never Events at The Ipswich Hospital NHS Trust

2012/13	2013/14	2014/15
1	3	3

Regrettably, three Never Events occurred in 2014/15.

- Wrong site injection in Ophthalmology. This patient was on the Lucentis pathway and the wrong eye was injected. No harm to patient as both eyes required treatment, she therefore had both eyes injected that day.
- Wrong side spinal root block. The patient suffered no harm and has recovered well.
- Misplaced naso-gastric tube. The patient was X-rayed following the insertion of the naso-gastric tube. The X-ray was very difficult to interpret.

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

A WHO SSC review group comprising medical, surgical, anaesthetic and allied health professional colleagues was developed 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 Hospital. 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.

Directors' Report

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.

Our performance

Incidents reported

For the year 2014/15, 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
Access, appointment, admission, transfer, discharge	647
Abusive, violent, disruptive or self-harming behaviour	46
Accident that may result in personal injury	1,681
Anaesthesia	10
Clinical assessment (investigations, images and lab tests)	202
Consent, confidentiality or communication	154
Diagnosis, failed or delayed	18
Patient information (records, documents, test results, scans)	241
Infrastructure or resources (staffing, facilities, environment)	163
Labour or delivery	311
Medical device/equipment	195
Medication	479
Implementation of care or ongoing monitoring/review	782
Other	131
Security	1
Treatment, procedure	184
Totals	**5,515**

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

Type of incident	No of SIRIs
Information Governance breach	3
Management of the deteriorating patient	7
Baby born in poor condition	4
Developed pressure ulcer grade 3 or 4	27
Wrong site surgery	2
Fall causing significant harm	13
Unexpected death	7
Possible mismanagement of care (delayed diagnosis)	1
Unplanned surgery	1
Complication of treatment	3
Possible mismanagement of care (misdiagnosis)	1
Stillbirth	1
Infection control outbreak	2
Allegation against staff	5
Possible mismanagement of care (delayed treatment)	2
Patient accident	1
Total	**80**

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.

Executives' 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 2014/15.

Pension contributions

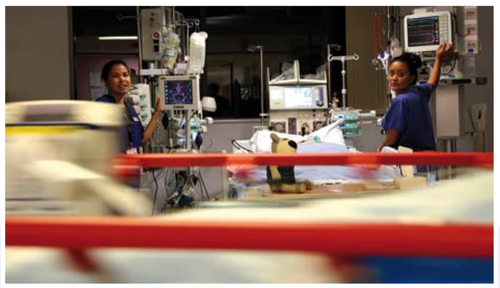
The Trust made contributions totalling £13.7million in the year to the NHS Pensions Agency, as per note 10.1 to the accounts. Note 10.6 in the Trust's accounts provides further details as to the nature of the pension scheme and accounting practice in relation to associated liabilities. Details of the pension benefits of the Trust's senior managers are also given in the Remuneration Report. Exit packages are referred to within notes 10.4 and 10.5 of the accounts.

Patients arrive in our Emergency Department at all times of the day.

Remuneration Report

Salary and Pension Entitlements of Board Members 2014/15 (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	3	14	42.5–45	210–215
Paul Scott Director of Finance and Performance	135–140	0	0	1	3	40–42.5	175–180
Julie Fryatt Foundation Trust Director	95–100	0	0	2	6	30–32.5	130–135
Clare Edmondson Director of Human Resources	95–100	0	0	0	0	25–27.5	125–130
Barbara Buckley Trust Medical Director	110–115	30–35	35–40*	4	14	152.5–155	330–335
Lynne Wigens Director of Nursing and Quality	100–105	0	0	6	21	5–7.5	110–115
Neill Moloney Chief Operating Officer	125–130	0–5	0	0	0	17.5–20	140–145
Ann Tate Trust Chair	20–25	0	0	2	8	0	20–25
Alan Bateman Non-executive Director	5–10	0	0	1	3	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	12	0	5–10
Laurence Collins Non-executive Director	5–10	0	0	0	0	0	5–10
Rajan Jethwa Non-executive Director	5–10	0	0	0	0	0	5–10

*Clinical Excellence Award.



A glimpse inside our Critical Care Unit.

Remuneration Report

Pension Benefits – Board Members 2014/15 (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 2015 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2015 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2015 £000	Cash equivalent transfer value at 31 March 2014 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Nick Hulme	0–2.5	5–7.5	45–50	135–140	891	807	63	0
Julie Fryatt	0–2.5	N/A	10–15	N/A	137	111	23	0
Paul Scott	0–2.5	2.5–5	25–30	85–90	427	379	31	0
Clare Edmondson	0–2.5	0–2.5	5–10	20–25	144	114	14	0
Neill Moloney	0–2.5	0–2.5	30–35	100–105	534	494	19	0
Barbara Buckley	0–2.5	2.5–5	60–65	180–185	1,217	1,026	26	0
Lynne Wigens	0–2.5	0–2.5	35–40	115–120	730	686	25	0

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

A ward's nursing station at night.

Remuneration Report

Salary and Pension Entitlements of Board Members 2013/14	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

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.

Off-Payroll Engagements 2014/15

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	16
Of which, the number that have existed:	
for less than 1 year at the time of reporting	12
for between 1 and 2 years at the time of reporting	3
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	12
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	12
Number for whom assurance has been requested	2
Of which:	
assurance has been received	2
assurance has not been received	0
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	13

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.

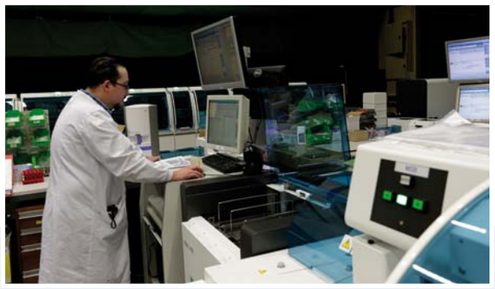
Median staff pay disclosure (Audited)

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 midpoint of the banded remuneration of the highest paid director in The Ipswich Hospital NHS Trust in the financial year 2014/15 was £177,500 (2013/14, £247,500). This was 6.6 times (2013/14, 9.23) the median remuneration of the workforce, which was £26,822 (2013/14, £26,822). Median pay was unchanged from last year.

In 2014/15, six medical consultant employees (2013/14, none) received remuneration in excess of the highest-paid director.



Pathology testing goes on throughout the night.

2014/15 Governance Statement

2014/15 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 Trust has an integrated governance approach to ensure decision making is informed by a full range of corporate, financial, clinical and information governance.

The Board

The Trust Board is comprised of a Chair, five Non-executive Director members and five Executive Director members: the Chief Executive, Medical Director, Director of Nursing 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. There are no Non-executive Director vacancies. The Deputy Chair acts as Senior Independent Director.

The Executive team has continued to stabilise during the year, building on the substantive appointments made in the previous year. The Board met a total of six times in public in 2014/15 with private Boards in the intervening months. Attendance was monitored throughout the year and there were eight absences by a Non-executive during this period and four from Executives. In November 2014 the Fit and Proper Person's Test was introduced as a statutory requirement by the Care Quality Commission. The Board received a paper detailing the requirements and has put in place an annual declaration for all Board members. The Board's Register of Interests was updated in May 2015 and it was formally received by the Trust. This will be reviewed and updated again and presented at the September 2015 Board.

From April 2014, the Board has met on a bi-monthly basis to enable more in-depth review of topics and to develop strategy. The public meeting follows a structured format, starting with a patient or carer story to set the tone and focus of the meeting, closing and excluding press and others as necessary for a part two confidential session. The patient/carer story is followed by matters of quality and risk, strategy, performance and corporate governance. The confidential (private) meeting, on alternate months, includes the opportunity to review any urgent items on a monthly basis as required. To ensure openness and engagement with stakeholders, patients and the wider health economy, the Chief Executive holds open forums in venues across the east of the county.

The Trust Board has undertaken a wide range of development activities during the year, with regular seminar time scheduled into its work programme. This time is used to ensure the Board is up to date with key issues in essential areas, for example in safeguarding, but also as an opportunity to consider in depth the future strategic issues facing the organisation. Experts within their field have been invited to contribute to the debates, for example when looking at the opportunities and challenges of becoming an integrated care organisation. The Trust's well-established relationship with Ashridge has continued in the past twelve months, which has seen them support the Executive, Non-executive and whole Board, focusing on ensuring effective relationships and understanding the differing roles and contributions of each role within the Board.

During the year the Trust has also worked with the NHS Leadership Academy on a review of the effectiveness of a revised operating model, following the introduction of our clinically led divisional structure in 2013. Contributions from the leadership tiers across the organisation, including the

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Board, were collated to identify the strengths, weaknesses and further opportunities for enhancing the organisational function. The findings were reported back to the Trust Board to provide assurance of the Executive leadership's continued commitment to ongoing improvement in effectiveness.

In confidential (private) sessions 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 Beliefs and Values and agreed strategic objectives. All Board members are actively encouraged to put forward topics for discussion in the confidential (private) sessions, which inform the agenda of dedicated seminar sessions.

Board Committees

There is an established and robust governance framework, supported and maintained by a structure 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 describe 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
- Strategy Steering Board (formerly the FT Steering Board).

The Audit, Healthcare Governance and Finance and Performance Committees are the main assurance committees reporting to the Board. The minutes are reported to the next Board Meeting. The Board may request further work on various issues which are raised.

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 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 normally 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 deterrence 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.

Of 27 reports finalised by internal audit, 25 were good or satisfactory and two were limited:

Level of Assurance	No.
Excellent	0
Good	9
Satisfactory	20
Limited	2
Unacceptable	0
Not applicable (control evaluation not appropriate)	0
Total	**31**

The two 'limited' assurance reports concerned the ARIA project and the Financial Systems. In relation to the ARIA project it was taking longer than originally envisaged due to the time needed for nurses to complete the quality assurance of clinical protocols, which presents challenges for engagement and presents a risk of running ARIA alongside a paper-based system. Although a formal methodology based on PRINCE2 is followed, there were weaknesses identified in the project documentation, including the main project spreadsheet not being fully up to date and incorporating all live risks. For the ARIA Project, the reorganisation of the Trust and the loss of key members of the project team meant the project faced significant challenges.

The financial systems audit found two issues of note:

- on occasions, the automated invoice approval system has been bypassed by manual approvals. This manual process has led to a number of invoices being paid above the value of the authorised signature. This highlighted control weaknesses within the outsourced accounts payable function and a lack of compliance with processes by budget holders. This has been addressed by compelling all invoices to go through an electronic authorisation process which ensures that an invoice cannot be processed without sufficient authority;
- password protocols in place with the provider of the Trust's financial system were not as robust as those following best practice. This was immediately corrected by the provider of the service.

It also noted that in transition to new financial systems, and an outsourced provider, agreed controls to prevent duplicate payments were delayed in implementation by the outsourced provider. This led to duplicate payments of circa £0.3m being made. On discovering this shortfall the outsourced provider implemented the agreed controls and recovered the full amount of overpayment.

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. It focuses on overseeing the development of risk management activities through the Risk Oversight Committee, which replaced the Risk Management Committee during the year.

The Healthcare Governance Committee receives assurance on the quality agenda and clinical governance activities through the Patient Safety and Clinical Effectiveness, Patient Experience Groups and the Risk Oversight Committee, 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. 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 are also members of the committee. 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 oversight of finance and performance issues 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 in 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 organisational efficiency.

The Audit, Healthcare Governance and Finance and Performance Committees submit an annual report to the Board to review

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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, Finance and Performance 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 and Finance and Performance Committees self-assessment results are discussed at the May committee meetings.

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 were reviewed and approved during the year.

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, Nominated Fund Manager, 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 and policy. The Trust Board met as corporate trustee to approve the Ipswich Hospital charitable funds annual report and accounts for the year ended 31 March 2014, 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 and amended at the end of the first quarter 2014/15 to reflect learning. There were a large number of policies that had exceeded their review date. Work is underway, through the new internal governance structure led by the Director of Governance, to urgently address this and ensure there is a robust process in place going forward.

The Trust's governance and quality structures were reviewed by Ernst & Young (EY) and a final report was received in quarter 4 (more details later in this statement). One of the governance recommendations was that all committee terms of reference, and those of the Board, should be reviewed annually to reflect the needs of the Trust. This was delayed as the Trust was undertaking its own governance review, which will see a new governance structure in place in quarter 2 2015/16. It was also recommended that attendance at Board committees should be mandatory for members and expected attendees. An action plan, with clear lines of responsibility, has been developed and will be subject to review by the Executive team with assurance provided by the **Strategy Committee.** Work will continue in quarter 1 2015/16 to respond to all the recommendations.

Divisional Structure

The Trust continues to embed the new divisional structures. The overarching intention remains one of supporting a clinically led organisation with a single line of accountability for all aspects of performance, including patient safety, patient experience, operational standards, financial performance and staff engagement. Importantly the introduction of the new structure sought to secure the engagement of clinicians, including doctors, nurses, midwives and allied healthcare professionals, in the leadership of the hospital. The structure comprises 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 does not significantly affect the composition or remit of the Board's assurance committees, it has resulted 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. A highlight report of the key issues discussed and decisions made is submitted to the next Board Meeting in Public following the Combined Board Meeting. 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. The Combined Board and the Divisional Boards have not undertaken a self-assessment of their performance over the last twelve months, but the Board can gain assurance that relevant matters are reported to the Board and that they are compliant with their Terms of Reference as the Chair of the Combined Board is the Trust's CEO who confirmed to the Board at its May 2015 meeting that the Terms of Reference for each committee have been followed throughout the year. The self-assessment process will form part of the agenda at the next Combined Board/Divisional Board meetings to ensure this is part of an annual review process.

Annual Quality Account (Unaudited)

The Trust Board under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 prepares a Quality Account for each financial year. Guidance has been issued to Trusts on the form and content of the Quality Account which incorporates the above legal requirements and requisite external assurance arrangements.

The Director of Nursing & Quality leads on the Quality Account. For 2014/15 the Quality Account priorities agreed by the Trust Board were informed by a number of sources such as patient surveys, staff surveys, complaints, compliments and the views of users and user groups.

Care Quality Commission

The CQC conducted a hospital inspection on 7 and 8 January 2015. They commented that the Trust had a relatively new Executive team, who worked effectively together to highlight issues and address challenges within the hospital. The comprehensive inspections result in a Trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. **The inspection found that overall the Trust has a rating of 'Good'.**

The Trust was found to be compliant in Outcome 4 (Care and welfare of people who use services) and Outcome 9 (Management of medicines); the areas of non-compliance identified in the visit in June 2013. Minor non-compliance was found in the documentation

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process for Do Not Attempt Resuscitation (DNAR) (Outcome 18 – Consent to care and treatment). Immediate actions were taken and an action plan developed to address the issues found.

How we addressed the issues raised by the CQC

Immediate actions were taken in the form of a Trust-wide audit of DNAR form completion with immediate rectification of any omissions or inconsistencies. An action plan was developed to ensure consistency with DNAR discussions with patient and family, and form completion.

- The Trust Medical Director sent an individual communication to all consultants and all junior medical staff reiterating the requirement for regular review of DNAR forms as part of ward rounds.
- Review of DNAR forms will be part of ward rounds supported by discussion at daily board rounds.
- There will be continuance of monitoring by Resuscitation officers and re-audit at regular intervals.
- Written information available for patients and their families has been reviewed.
- Shift handover guidelines for nurses have been reviewed.

The existing audit programme to check compliance has been increased:

- A spot check audit of 20 DNAR forms or a representative sample of one-third of patients every two weeks and an audit of all patients every quarter.
- A baseline audit of all patients was completed in January 2015 and will be repeated in April 2015.
- Any omissions found on audit will be reported via the Datix incident reporting system and discussed with the relevant consultant.
- Audit findings will be disseminated through Divisional Governance meetings via the divisional performance accountability framework, the Patient Safety and Clinical Effectiveness Group and Healthcare Governance Committee meetings.

Details of all the Trust's inspections can be found on the Care Quality Commission website at www.cqc.org.uk/directory/rgq02

Serious Incidents

The Trust has received the updated Never Events framework and Serious Incident policy circulated nationally. The Director of Governance is reviewing the Trust's current policies to ensure these are updated in line with the national changes with implementation by July 2015. In the meantime the framework is being reviewed within the Serious Clinical Incident Group (SCIG) processes to ensure reporting of serious incidents and never events is in line with national guidance and that all supporting policies are consistent with the guidance. The Trust has reported 100% duty of candour recording in relation to these serious incidents.

The Trust has contributed to an individual management report in relation to an Adult Safeguarding Serious Case Review which has been developed by Suffolk County Council as the lead agency. The Trust has been a contributor to a Serious Case Review lead by the Local Authority relating to care of a patient with learning disabilities. The final report will be available in 2015/16. All lessons from an IHT perspective have been implemented. All serious incidents, never events and claims are presented to the Board and assurance is provided through discussions at the Healthcare Governance Committee, which receives reports from the SCIG.

Board Effectiveness Review

The Trust commissioned an external review of its governance and quality governance arrangements during the financial year. The structures it used to carry out these reviews were those recommended by Monitor, specifically the:

- Well-led framework for governance reviews: Guidance for NHS Foundation Trusts; and
- Monitor's Quality Governance Framework.

After a competitive selection process Ernst & Young (EY) were chosen to lead on this work. EY reviewed the processes, structures and approaches the Trust operates to ensure that board governance and quality processes were delivered effectively and efficiently, monitored and continuously improved. They did this by reviewing the documents provided by the Trust, including its own self-assessments, holding discussions with Board members and senior Executives and attending meetings with other stakeholders.

Their final reports were received at the Trust in February 2015 and a number of recommendations were outlined in the reports. This was discussed at the Strategy Steering Board, which is chaired by the CEO and has a Non-executive member, who will decide on the full governance process. The reports were also circulated to all Board members for information and will be further discussed at the appropriate Board committee, either or both of the Healthcare Governance and/or Audit Committee before final presentation to the Board.

EY were instructed to treat the assessment as a diagnostic review to support the development of the Trust's governance arrangements. An action plan identifying over 80 activities to strengthen Board and Quality governance has been drawn up. There were 32 immediate and 17 medium actions, with four Amber/Red assessments. A number of the immediate recommended actions from the review have already been completed, for example, increasing the frequency of the Healthcare Governance Committee meetings, and the detailed action plan is being developed to address all the recommendations during 2015/16. This work will be assisted by the development of the new governance structure.

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 Trustwide.

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 (Table 1, page 48).

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 2014/15 and were reviewed by the Trust Board.

- There is a risk of contaminated chemotherapy due to poor fabric of the Aseptic Preparation Unit and exceeding capacity.
- The absence of consistent policies and procedures in Outpatients could adversely affect clinical outcomes.
- The tightening financial outlook may restrict the Trust's ability to provide services.
- Clinical Commissioning decisions may affect the sustainability of some services.
- The inability to meet operational standards/key performance indicators in Emergency Department could damage the Trust's financial and reputational position.
- There is a risk to patient care and experience if the environment of the Oncology Day Unit is not changed.
- The inability to recruit effectively to well-planned staff establishments will impact on quality of care and patient experience.
- Ageing electrical infrastructure with associated risk of failure could cause service interruption.
- There is a risk of injury to Mortuary staff and to dignified handling of deceased due to poor design of storage areas.
- A number of policies are out of date, which could compromise patient safety.

The **Risk Oversight Committee** (previously 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.

The Trust's approach to risk management has been made available to all staff and risk management information is

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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

included in Trust induction training and subsequent updates. Staff also undertake mandatory training such as manual handling, information governance, 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 (eg 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 Oversight Committee.

Work started in 2012/13, to align risks to the three assurance committees via the NPSA framework and to the Trust's strategic objectives, has continued in 2014/15. Further work to improve risk processes commenced in the fourth quarter of 2014/15 with a review of the Board Assurance Framework risk identification process and reporting mechanisms together with a review of the risk register. A task-and-finish group comprising two Non-executives and Executive Directors, supported by the Director of Governance, was proposed and delivered a work programme in April/May 2015 reporting its findings at the May 2015 Public Board. Changes to risk reporting at Board level in the year have included the introduction of information on all risks scoring 15 and above.

The Trust formally investigates all serious clinical incidents (Serious Incidents Requiring Investigation – SIRIs), reports its findings via the Risk Oversight Committee and this process is assured by the Healthcare Governance 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.

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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 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.

The Quality Account is currently unaudited, however, the audit is currently ongoing and due to be completed by 30 June 2015.

Whistleblowing

The Trust encourages all staff to report bad practice or any mistreatment of patients receiving care from the Trust. In its leadership role, the Board provides a range of processes to enable all staff to report their concerns promptly and in ways that they are comfortable with. All staff should be confident that they can raise concerns without fear of reprisal and guidance is available in the Trust and access to external guidance is signposted. Following the publication of Sir Robert Francis's report 'Freedom to Speak up' and a letter from the Secretary of State, the Senior Independent Director provides independent confidential support to staff so they can speak up if they feel their concerns are not being listened to. The Trust is in the process of identifying another member of staff to provide this level of independent support.

Review of Economy, Efficiency and Effectiveness of Resources

The financial position of the Trust has deteriorated during the course of 2014/15 with a £11.9m deficit after accounting for impairments and other technical adjustments. A number of factors have contributed to this deterioration, including an increase in non-elective activity, resulting in increased costs to maintain delivery of the service, together with a loss of theatre productivity, which led to increased pay costs, especially agency provision.

The Trust routinely reviews its budgetary controls system via the internal audit function. This was found to be satisfactory. Divisional teams signed up to delivering their budgets at the start of the year after a comprehensive business planning process. These budgets were not delivered due to risks identified at budget setting not being managed and an unprecedented growth in non-elective activity. These issues were spotted early and financial recovery plans were developed to try to address the risks. These did not have the anticipated impact.

We recognise that this needs improvement and the Trust has taken this requirement into its planning for 2015/16 and will establish appropriate contingencies. Furthermore, further development of the financial information, improved accountability at specialty level and appropriate organisational development will support this.

The accounts have been prepared on a going concern basis, noting that the Trust delivered an adverse variance to plan of £7m in 2014/15. This was due to increases in non-elective activity above contract which resulted in a marginal tariff rate of 30% of normal and premium costs. The Trust also suffered volatility in theatre productivity resulting in additional sessions being paid. The Trust Development Authority supported the Trust in securing a Public Dividend Capital cash injection that is not considered repayable of £7m that supported this adverse variance. The Trust is forecasting a £19.8m deficit in 2015/16. This has been reviewed with our regulators, The Trust Development Authority, who have indicated that this plan is acceptable. The plan incorporates a requirement for cash support which the Trust expects to be in the form of Public Dividend Capital. The Trust has a short term working capital facility to support this position and will prepare, with the Trust Development Authority, an application for further cash injection via Public Dividend Capital to support the deficit plan. The Trust Board has reviewed this position and believe it to be an appropriate plan at this stage in the Trust's development. The Board is monitoring the progress with the cash application and is overseeing the development of a longer term sustainable plan.

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Data Security

In 2014/15 the Trust achieved a satisfactory 'green' assessment at 84% for its information governance assurance under the Information Governance Toolkit. This is an improved score on the previous year.

The Information Commissioner's Office (ICO) undertook an agreed two-day 'Risk Review' following the Trust reporting that between November 2013 and July 2014 there had been four breaches where patient identifiable data stored in a paper format was lost. The ICO were satisfied that the Trust is implementing good practice, in particular, the content of the IG training for staff was found to be fit for purpose and the IT 'paperlight' strategy will help to further reduce the use of paper within the Trust. The Trust is currently reviewing the ICO recommendations in relation to confidential waste arrangements. It was also recommended that the Trust minimised the use of processes involving paper, such as ceasing the use of standalone fax machines and providing the community midwives with secure means to transport patient data in the community. This has already been reviewed as part of the 'paperlight' strategy and the community midwifery team will be provided with laptops instead of carrying folders.

The ICO sent out an online survey to all staff as part of the audit. 495 responses were received, which was in excess of the target of 10% of the staff workforce. The ICO commented there was a high level of staff awareness surrounding the incidents that led to the visit, which demonstrated shared learning across the Trust.

Performance Against National Priorities Set Out in the NHS Constitution 2014/15

During 2014/15 the Trust has demonstrated good performance against the key performance indicators. Key achievements this year include:

- Full-year compliance at 96.29% across 2014/15 achieving across all four quarters with the 95% threshold for Accident & Emergency four-hour waits.
- Compliance across the 18-Week admitted (90.4%), non-admitted (95.8%) and incomplete thresholds (95.2%) across the 2014/15 reporting year at a Trust level.
- Compliance across the 2-Week, 31-Day and 62-Day Cancer Treatment targets across 2014/15 as a reporting year.
- The Trust achieved the 99% compliance required on diagnostic tests undertaken within six weeks achieving 99.44% across the year.
- The Trust also achieved compliance with the requirement to cancel no more than 1% of patients' operations on the day for non-clinical reasons achieving 0.62%.

The Trust did not achieve its MRSA trajectory of no more than zero cases in year, recording one case across 2014/15. The Trust also exceeded its C.difficile trajectory for no more than 23 cases in 2014/15 with 25 cases, although four of these cases were upheld following appeal.

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. However, there were reports of limited assurance. The limited assurance reports related to financial systems and the ARIA project as discussed earlier in this report. In addition to the Head of Internal Audit opinion, the Audit Committee Chair provides the minutes of each committee meeting, together with a brief summary highlighting areas for the Board's attention, 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.

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Every month a report is prepared by the Finance Department for the Audit Committee. The report highlights any recommendations which are past their due date, listed by division.The report indicates new recommendations and those which have been closed during the reporting period. This process is not yet mature and appropriate disclosure is made in the monthly NHS Trust Oversight self-certification.

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.

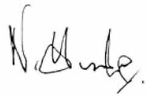
Conclusion

With the exception of the internal control issues that I have outlined above in this statement, my review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been, or are being, addressed.

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:



Date:
03 June 2015

Inside the Security suite.

2014/15 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 2015

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.

Our Pharmacy operates through the night as well as the day.

Annual Report 2014/15

2014/15 Governance Statement

Head of Internal Audit Opinion on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2015

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.

We note that the Trust is currently forecasting a year-end deficit of £12m, compared to an original budget of £4.9m deficit. Our opinion on the organisation's system of internal control has taken this factor into account.

My opinion is set out as follows:

1 Overall opinion;
2 Basis for the opinion; and
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.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes eg any reliance that is being placed upon Third Party Assurances.

TIAA and CEAC carried out 29 assurance reviews, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Ipswich Hospital NHS Trust's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided.

A summary is set out below.

Assurance Assessments	Number of reviews
Excellent	0
Good Assurance	9
Satisfactory Assurance	20
Limited Assurance	2
Unacceptable	0

Name: **N Abbott**

Date: **May 2015**

Head of Internal Audit

Declaration of Interests

Declaration of Interests 1 April 2014 to 31 March 2015	
Ann Tate Chair	• Governor of Rattlesden CEVC Primary School
Alan Bateman Non-executive Director	• Paid employee of Sailstone Ltd
Laurence Collins Non-executive Director	• Vice Chairman of Gymnastics in Ipswich • Governor of Rushmere Hall Primary School, Ipswich
Andrew George Non-executive Director	• Director of Suffolk Mind • Member of Standards Committee for Suffolk County Council and other Suffolk Councils
Rajan Jethwa Non-executive Director	• Chief Executive Officer of Microtest Matrices Ltd • Sole Director of the Erudite Evolution 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	• Spouse is a Trustee of Suffolk Family Carers
Barbara Buckley Medical Director	• Nil
Clare Edmondson Director of Human Resources	• Partner – Badwell Ash Holiday Lodges
Julie Fryatt Foundation Trust Director	• Motor home rental business trading under the name Sunrise Motor Homes
Neill Moloney Chief Operating Officer	• Director of Casemix Ltd
Paul Scott Director of Finance and Performance	• 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)

Ambulances outside our Emergency Department.

Glossary of Terms

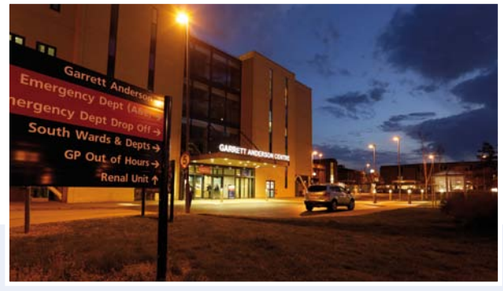
Glossary of Terms

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

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 and printed by our Design and Print Services team. Photography is by our in-house Clinical Photography team with contributions from freelance photographers.



The Garrett Anderson Centre.

The Ipswich Hospital NHS
NHS Trust

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

Further copies of this report are available from:
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IP4 5PD
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Email: press.office@ipswichhospital.nhs.uk

This Trust is working towards equal opportunities.

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