NHS
The Ipswich Hospital
NHS Trust

Sharing our story...







Ipswich Hospital
Annual Report and Accounts 2016/17

Our Passion, Your Care.

Welcome

Sharing our story...

For our design theme this year, we have chosen to feature some of our good news stories from the past year.

Front cover news photographs:

Row 1

Baby friendly award
Musculoskeletal Admissions
Dementia-friendly wards

Row 2

Staff commendations
Year of specialist Fertility care

Row 3

Emergency Therapy Team
Technology upgrade in Theatres
Frailty Assessment Base

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 and freelance photographers.

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

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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 نەم بەڵگەیەتان بە ماناێکی تر هەبێت، تکایە لە یەکێ لە هەواڵانی خۆتان کە بە ماناێ نینگلیزی 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 Department of Health Group Manual for Accounts 2016/2017.

The Quality Account 2016/17 is a companion document to this report and is available online at www.ipswichhospital.nhs.uk

Performance Report

Overview

Chair's Foreword

As I reflect upon our work at Ipswich Hospital over the past year, I am mindful of the many changes that we have seen over the lifetime of the NHS which will soon be 70 years old. Year on year we have seen increasing demands upon our services against a background of rising public expectations as to what the NHS is here to provide. Every year there are thankfully medical advances which both save and improve lives. As we go forward it is important that we see these medical breakthroughs as being part of a wider story of how the NHS is continuing to change in light of a challenging financial position. Matching and meeting demand within the resources available is our goal.

David White
Chair

Cooperation and collaboration across all parts of the NHS and with local government is now much more the order of the day as we continue to move towards providing joint services which best meet the needs of patients. Building upon our successful experience of running three community hospitals across east Suffolk during the last year we will shortly become even more centrally involved in running NHS community services along with GPs, the mental health service and social care. The principle is to make sure patients get the care they need where and when they need it. We want to improve patient experience and take pressure off our busy hospitals through care closer to patients' homes. It is an exciting and challenging time of breaking the mould.

> "We have much good news to share with you. It has been a really busy but very productive year at Ipswich Hospital."

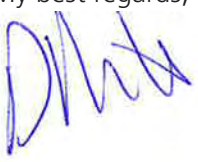
In May last year the Chief Executive and I were asked to work with the team at Colchester hospital to help make improvements. Since then both of us, holding joint appointments between the two Trusts, have been developing a long-term partnership between the hospitals which will strengthen both of our futures.

The two hospital teams are working closer together and in January both Trust Boards signalled their intention to formalise this partnership arrangement. It's important to stress that each hospital will continue to have, among other services, an Emergency Department, maternity and acute medical services on site. We are now having conversations with our clinicians, commissioners and partners about our emerging proposals, but no formal decisions have yet been made. In the year ahead we will expand these conversations to patients and communities.

We have much good news to share with you. It has been a really busy but very productive year at Ipswich Hospital with the opening of two new dementia-friendly wards, a new frailty assessment base and a new musculoskeletal surgery admissions unit. We've upgraded our pathology laboratory, extended our emergency therapy team and committed to speeding up the diagnosis of cancer. You can read more about our achievements throughout the pages of this report.

I am very proud of what our staff achieve, day in, day out in caring for and supporting patients. A very big 'thank you' to all staff for your contribution and, indeed, also for the tireless support given by the many volunteers who are actively involved in the work of the hospital.

My best regards,



David White
Chair
30 May 2017

Overview

Chief Executive's Overview

The most important question we can ask our patients is 'What matters to you?'

As healthcare professionals it's easy for us to assume we know best. But when it comes to the care we should be providing you, it should be the care you want.

For some of you that means getting home as soon as possible, for others it is seeing your consultant regularly. It could be as simple as your bedtime in hospital or having wi-fi so you can stay in touch with the outside world.

What matters to us, the team which runs the hospital, is letting our clinical staff provide top-class care – the safe, compassionate and high-quality care we are very proud of at this hospital. But when we are thinking about the future of care we need to remember we are not an island. We are part of a strong NHS which works best when we work together.

I'm pleased to say I believe we are on the right path. We are working closely with all the key health and social care organisations in north east Essex and east and west Suffolk to make sure that by 2021, the one million people who live in this area will have healthier, happier lives. It is called our Sustainability and Transformation Plan (STP). We aim to replace local competition with local collaboration. We want to avoid duplication and waste and make services simpler to access.

Health and social care faces huge and immediate challenges – more patients with complex long-term conditions, a dwindling workforce, tighter budgets – and the STP will set us on the road to a better future.

Nick Hulme
Chief Executive

> "I'm confident the team in Ipswich will continue to deliver high quality care."

We are also building a long-term partnership with Colchester hospital, where I am also Chief Executive. In the medium to long-term, neither organisation is financially or clinically sustainable on its own. The partnership will give us an opportunity to build strong futures for both hospitals and I'm confident the team in Ipswich will continue to deliver high quality care as the partnership progresses.

Both the STP and the Colchester partnership are showing the real advantages of working together, not just sharing best practice, staff and ideas but in the support the hospitals can give each other – the whole being greater than the sum of its parts.

We have big ambitions to be outstanding providers of health services and we have put together a plan called 'Writing the next chapter' which explains how we are going to get there. I am delighted that so many of our partners, colleagues, voluntary organisations and local people took the time to give us much considered feedback on the strategy. Success for us will look like this:

- an 'Outstanding' CQC report;
- exemplar patient and staff experience;
- top 10% safest hospital in the UK;
- improved detection and treatment of common preventable disease;
- delivering increased activity within 2016/17 cost base.

While all these strategic intentions are crucial, we remember that what really matters is the day-to-day contact we have with our patients. It's the way we answer the phone to people, the care on the wards, the compassionate delivery of bad news and the kindness extended to our patients' loved ones.

When you visit the hospital, please take time to tell us what matters to you.

Nick Hulme
Chief Executive
30 May 2017

Overview

About The Ipswich Hospital NHS Trust

We are an organisation with a proud history and one that has long adapted and responded to changes in health needs and circumstances.

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

Every day over 3,000 patients rely on us to improve their lives. Our services include accident and emergency; critical care; planned medical and surgical care; consultant and midwifery-led maternity, and neonatal and paediatric care; diagnostic and therapy services; and since October 2015 community hospitals and specialist community services.

We also provide a range of specialised services including spinal surgery, radiotherapy, percutaneous coronary intervention (PCI) and gynaecological cancer surgery to a wider catchment of more than 500,000 people.

The Trust has 552 beds in general acute, maternity, paediatric and neonatal services and had an annual turnover of £266 million in 2015/16. Across its 46-acre site, we employ just over 3,400 whole time equivalent NHS staff.

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.

93% of the services provided by the Trust are commissioned by the Ipswich and East Suffolk CCG.

The Trust has a catchment population of approximately 390,000 people, primarily drawn from the districts of Babergh, Mid Suffolk, Suffolk Coastal and Ipswich. We have a typically older catchment population than the UK average, with a greater proportion of the population aged over 55. The population is projected to increase by 3.7% by 2021. However, there is estimated to be an overall 13.6% increase in the catchment population of those 60 and older by 2021, and a 40% increase by 2037. Our catchment population has a longer life expectancy than that of England, alongside a lower mortality rate in the main disease areas. This mortality rate is also decreasing over time, despite an increasing – and increasingly elderly – population. In contrast, the catchment population

Sharing our story...

Musculoskeletal Admissions Unit

An admissions unit opened to improve patient experience for people having planned musculoskeletal surgery.

It means many patients do not need to come into hospital until the day of their operation and it helps theatre lists to start on time.

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About The Ipswich Hospital NHS Trust

typically has a higher rate of disease prevalence than England. Combined with reduced mortality, this indicates an increased amount of co-morbidities, and people living for longer with poorer health.

Patients attending with mental health issues represent around 4% of Emergency Department attendances, or in excess of 3,000 attendances a year. An analysis of this cohort indicates that these patients are more than twice as likely to re-attend and also have a higher average length of stay when admitted.

Building on a solid foundation

Over the last three years we have:

- strengthened grip and productivity across clinical and corporate services;
- reduced length of stay;
- improved quality of care by redirecting funding to invest in safer staffing;
- created a regional spinal centre;
- created a Single Point of Access;
- built the Ipswich Heart Centre;
- partnered with Macmillan Cancer Support to build Woolverstone Day Unit;
- built a new drug centre for the manufacture of chemotherapy drugs; and
- redesigned central Outpatient reception and waiting area.

Across the hospital we have carried out 'Red-to-Green' weeks. These target specific services and departments to improve delivery, for example the Emergency Department. The Red-to-Green concept won first prize in the 2016 HSJ awards, in the value and improvement in emergency medicine category. Red-to-Green weeks have served to identify key constraints and areas for improvement within the Emergency Department and relieved pressure during busy periods in winter. This has helped patients return home more quickly and maintain their independence.

We are starting to change patient pathways to support people to live and be treated in the community. Our review of technology has led to the hospital being one of the early adopters of Lorenzo Regional Care to drive change and deliver additional capacity as it underpins operations as a key enabler to working differently.

Over the next five years we will continue to evolve our organisation, responding to both internal and external changes, to become an outstanding provider of health services for our population.

Changing landscape

The Trust has developed a clear vision of where it wants to be over the next five years, alongside and consistent with the Suffolk and North East Essex Sustainability and Transformation Plan. In the immediate future there are three key decisions which will affect the way in which our vision is delivered but not the overall destination. These are:

- Community services contract – The current contract, managed by West Suffolk NHS Foundation Trust, Norfolk Community Health and Care NHS Trust and Ipswich Hospital NHS Trust expires at the end of September 2017.
- Colchester Hospital University NHS Foundation Trust (CHUFT) – a Strategic Outline Case to outline the shortlist of options for developing the partnership between CHUFT and Ipswich Hospital was approved in January 2017. A final decision will not be made until later.
- The Pathology Partnership (TPP) – Following the servicing of notice by Cambridge University Hospitals NHS Foundation Trust to withdraw as host of TPP, a new entity has been created – North East Essex and Suffolk Pathology Services – hosted by CHUFT.

Our plans in 2017/18

We're going to be making some changes this year, and we'd like you to hold us to our promises.

There are some things you should take for granted, but we'll be working hard to make sure they are always there so you get care as quickly as possible. This means always getting seen quickly when you come to the Emergency Department, always getting the operation you need when you need it, without being cancelled (unless you are unwell); and always being treated with respect and kindness no matter who you are talking to.

Part of the way we'll do this is by changing the way some health issues are treated. So instead of seeing a consultant when you come into the Emergency Department, you might see a GP or

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nurse instead, but they'll be here on the hospital site so you won't be turned away.

We'll also change other ways of treating you so you only have to wait to see a consultant when really necessary. We'll be providing GPs with more specialist advice so they can start your treatment instead of you coming to hospital; by asking the right questions at the start we'll get you to the right place to be treated straightaway so you're not shunted from pillar to post; we'll also find new ways to provide care and support, such as apps on your smartphone, so you only come back to hospital when you really need to but you have all the advice and support you need while you get better – we'll only be a phone call or email away and we'll see you quickly if things get worse.

We're also committed to getting a confirmed diagnosis for patients with suspected cancer much quicker – 28 days at the latest.

If you do have to come in to hospital you will start to see a whole new way of working. We'll be offering more appointments on Saturdays, and the weekend will feel more like a weekday than before with more staff around and more tests available whatever the day or time.

You will also see a shift in attitude if you are admitted to a ward. It is not right for everyone but wherever possible we'll get you up for breakfast and keep you out of bed – even sitting in a chair is better – otherwise muscles waste away and it becomes even harder to get back to how you were. And the older you are the harder it gets, so it is even more important if you want to get back home.

We'll also be doing more to keep you at home. We'll be working with teams in your local area to bring help to your home when you need it, rather than you coming in to hospital. We'll also be making sure you can get home quicker after you've been in hospital. We'll have slicker processes to get you the support you need at home, or we'll give you some hospital care in your own home, or just come in for a visit, rather than spending your days in a hospital bed. We will be working with care homes as well so they will get this same great service too.

There are times however when we can't fix what is wrong, but too many patients still die in hospital when they really just want to be home. These can be difficult discussions for patients and their families, so we are committing to starting these conversations with you at a better time, giving you time to think and plan for what will eventually happen, rather than making hasty decisions when it is too late to have a proper conversation with the person who is dying. Your last days are your most precious and we will help you to live those how you want to.

But first days are also precious and we'll be talking to you about how our midwifery teams will be working to improve their service to you in a number of different ways. These changes will include the mental health of new mothers, and incorporating mental health and wellbeing into the care we provide will be a feature of a number of changes we are making.

We know that having an ill child causes concern for the whole family, so we will be changing the way we work with others to make sure children are seen as quickly as possible by the best person to help them.

We also understand the hospital can be a daunting place for children and families. With your support we will change the environment where children are treated, and improve where children stay overnight, so that if they do have to come into hospital it will be a more welcoming place, and more like a home from home than a hospital.

You won't see all the changes from day one, but this is the start of how we will make sure there is a hospital in Ipswich that can care for everyone, whatever their need, for a long time into the future. Please help us to keep our promises, so we can keep our promise to you of providing high quality compassionate care, when and where you need it.

Overview

Vision, goals and strategic objectives on a page

Vision	**To be an outstanding provider of health services for our population**			
Values	**Respect Kindness Listen & involve Professional Efficient Improving together**			
Success is…	✓ an 'Outstanding' CQC report; ✓ top 5% for the experience of care, and recommended by 97% of patients; ✓ top 10% for safety, as measured by the summary hospital-level mortality indicator; ✓ improve early detection and treatment for hypertension, atrial fibrillation, COPD and diabetes; ✓ constraining costs from 2017/18 to 2021/22, to support local STP financial recovery; and ✓ top 25% for staff satisfaction and engagement.			
Goals	**Deliver a great care experience**	**Be recognised as a leading innovator in healthcare nationally**	**Financially secure**	**Improve the experience of working in healthcare**
Strategic Objectives ***What we need to do***	• Work with others to deliver seamless, safe patient pathways across the system, supported by consistent communication. • Improve the environment that care is delivered in. • Ensure we deliver all care in accordance with our values.	• Embrace new ideas to deliver new, technology-enabled, financially viable ways of working. • Improve the health of our population and the use of self-care tools. • Increase provision of care in the community. • Push the boundaries through innovation and managed risk taking.	• Meet increasing demand without increasing resources. • Use resources more effectively to maximise efficiency of service models/ patient pathways.	• Engage and train staff to continue to deliver, and support the delivery of, care in a changing environment. • Proud of the care we provide. • Empower staff to take personal responsibility every day.
Primary Key Performance Indicators (KPIs)	• Provide increased community-based care to constrain emergency admissions to 2016/17 levels. • 25% reduction in the number of people dying in hospital.	• 60% reduction in outpatient follow-ups without a decline in outcomes. • All residential/ nursing homes to be supported by technology, training, education and collaboration.	• Top 10% for efficiency, as measured by Carter. • 13% reduction in agency expenditure from 2016/17 baseline.	• Top 25% for communication from management. • Top 25% for training and appraisal satisfaction.

Overview

Trust Objectives

Key Risks and Mitigations

Risk	Likely to manifest as:	Risk management and mitigation
If we are unable to fill our staffing rotas then we will not meet patient needs consistently	• Potential for reduced quality and coordination of care • Negative impact on patient flow and access targets • Long-term impact on staff resilience and poor retention of staff	• Use of agency staff with resultant impact on financial plans • 3-month/12-week rosters prepared • Dedicated work to improve recruitment process and attractiveness as employer • Working across system to address workforce shortages and jointly manage impact
If system partners do not work optimally together then we will not deliver the best care for patients	• Organisational priorities are placed ahead of patients' needs • Sub-optimal pathways are developed and implemented • Too many patients are treated in the hospital and not in more appropriate places	• Alliance approach removes key organisational barriers • Engagement and relationship building with key partners • STP strategy sets shared principles agreed by all partners
If business planning risks are not adequately controlled then we may not be able to provide the level and scope of services currently offered to our local community	• Deterioration in contractual performance • Deterioration in quality of service provision	• Guaranteed income contract creates shared incentives • Devolved budgets and local delegation to clinical leaders supported by moderation and oversight • Supporting division to identify opportunities and mitigating actions • Delivery of sustainability and transformation programme
If staff do not have the required knowledge of the CQC fundamental standards for their role, there is a risk of patients receiving sub-optimal care	• Poor patient experience • Failure to meet regulatory obligations • Threat of regulatory sanctions	• Clear clinical leads identified for each area • Trust procedures reflect CQC standards where relevant • Staff CQC booklet provided on induction • Establish a clinical governance assurance framework • Continual dialogue with regulators as service changes are made

Continued overleaf

Overview

Quality

Key Risks and Mitigations (continued)

Risk	Likely to manifest as:	Risk management and mitigation
If we fail to recognise and manage suspected sepsis early then patient outcomes may be affected	• Poor outcomes for patients • Additional costs of treatment and length of stay	• Sepsis guidance and training for staff • Sepsis prompt section on drug charts • Updated policy to reflect latest NICE guidance • Explore business case for sepsis module on nerve centre • Explore business case for sepsis nurse specialist role
If site-wide redevelopment of the hospital estate does not occur then some parts of the estate may become unfit for purpose	• Parts of estate become unmanageable • Service users affected	• Backlog maintenance programme managed through Estate Strategy Board • Develop options for Bridge School and north end • Premises Assurance Model
If we do not have sufficient capacity with the appropriate skills and abilities in transformational management then we will not be able to realise our planned benefits	• Failure to deliver financial savings though cost reduction • Need to employ premium capacity resource to maintain access standards for patients • Implications for cash flow	• Streamlined programme management and planning processes • Capacity assessment undertaken • Sharing of redesign resources with commissioners • Use of temporary staff to focus on delivering sustainable change
If we do not plan for financial sustainability through transformation then we will not be able to provide the level and scope of services currently offered to our local community	• Deterioration in contractual performance • Inability to deliver Trust strategy • May lead to Trust being put into special measures by regulators	• Refresh of Trust strategy alongside STP to identify opportunities • System-wide work focussing on transformation • Internal transformation programme to improve efficiency of support services
If the Trust does not deliver the Cost Improvement Programme then we will fail to achieve financial objectives	• Increased Trust deficit • Cash shortfall	• Business planning cycle to identify CIPs • Accountability Framework to hold divisions to account or CIP delivery • Sustainability and Transformation Portfolio Board to oversee Trust-wide CIP delivery at programme level
If we are unable to secure cash support for our financial plan then we may not have sufficient cash to ensure payments are made in a timely manner	• Failure to meet access standards • Sub-optimal outcomes for patients • May not be able to sustain level and scope of service provision	• Extension of working capital facility • Cash management controls • Deliver STF fund trajectories

Overview

Quality

Approach to Quality Governance

The Director of Nursing and the Medical Director are joint executive leads for quality of care and clinical outcomes, supported by the Director of Governance, whilst recognising that everyone is responsible for quality. The Trust works on a risk and escalation basis for managing quality, and this has been built into our structures and processes.

Quality governance comes together through the Quality Committee, which is supported by:

- Sub committees covering patient and staff safety; clinical effectiveness and patient and carer experience. These groups also oversee groups such as the mortality review group, and Divisional and Clinical Delivery Group level governance meetings which cover all aspects of quality;
- Dedicated audit days and clinical audit function;
- Schwartz rounds and after action reviews (AARs);
- Comprehensive SIRI investigations and reporting;
- Quality priorities reporting to Board through the Integrated Performance Report;
- Quality metrics embedded into the Trust's Accountability Framework;
- Ward level capture and reporting on quality and safer staffing; and
- Quality heat maps reviewed monthly by the Board.

Our measures of success for quality improvement being agreed through our refreshed strategy are:

- Reduction in complaints regarding communication;
- Reduction in number of people on end of life care dying in hospital;
- Reduction in unwarranted clinical variation, as measured by Carter;
- Reduction in delayed discharges of care;
- Minimise delay of clinical support services in patient pathways;
- Improvement in the Patient Led Assessment of the Care Environment review; and
- Improvement for patient recommendation scores.

Sharing our story...

Three specialist midwives

We've invested in Maternity care this year including the appointment of three specialist midwives. Mothers are now able to access better support thanks to a consultant midwife, a bereavement midwife and lead midwife for perinatal mental health

Overview

Quality

Quality Priorities for 2016/17

Priority	Target	Key measures
To continue to develop services to support patients who are elderly and frail	• To increase the number of patients using the Frailty Assessment Base (FAB) service • To reduce the length of stay in both the acute and community hospital setting for those patients who need to be admitted following assessment • To increase the percentage of patients who have managed to avoid admission and remain at home • To expand service to become available seven days a week • To further integrate with community services and social services	• Monitor the number of patients referred to the service • Monitor the length of stay of those patients who require admission following assessment by the Frailty Assessment Base • Monitor the number of admissions avoided
To continue to improve our care to those at the end of their life and support patients who have limited treatment options	• To deliver high quality, compassionate and dignified end of life care for all patients	• Monitor themes from feedback relating to end of life care • Monitor results from DNACPR and national end of life audits to highlight themes for improvement • Audit use of individualised care plans to ensure best possible practice • Expand post bereavement follow-up service with families • Monitored attendance at palliative and end of life care training sessions
To avoid delays in transfers of care of a patient from hospital or community beds to other care environments	• To reduce the number of patients who have to stay in our hospitals beyond the date when they are medically stable for discharge	• Number of patients who have a delayed transfer of care (DToC)
To continue to expand our dementia-friendly environment	• Creatively re-furbish two further wards to provide a shared clinical and social environment using The Kings Fund's Enhancing the Healing Environment and other existing research in the design process • To share the learning from creative refurbishments with other areas	• Track progress of works to improve ward environments to ensure all work is completed within the agreed timescale • Measure the numbers of incidents of violence and aggression in these areas • Patient, carer and staff experience findings • Staff sickness and retention in these areas

Overview

Quality

Sharing our story...

Technology upgrade in Theatres

New technology was rolled out throughout Surgery to revolutionise the running of operating theatres. We became the first hospital in the UK to use the new software – Lorenzo Theatres Module – to improve patient safety.

Seven-Day Services

The Trust continues to develop clinical services to meet the standards established for Seven-Day working across the NHS.

Progress is assessed, and reported to NHS England, via bi-annual audits of compliance. In common with most NHS Trusts, Ipswich Hospital NHS Trust continues to work towards full compliance with the standards. Against the four priority standards, the Trust remains fully compliant with standards 5 (Access to Diagnostics) and 6 (Access to Consultant Directed Interventions). For standards 2 (Time to Consultant Review) and 8 (On-going Review) the Trust continues to improve compliance. It is compliant in regard to patients assessed as having greater clinical acuity/need and in broader terms is reported in the published data as performing in-line or ahead of the regional and national mean performance against each standard.

The Trust recognises the importance of achieving the core standards for Seven-Day services in relation to patient safety, clinical outcomes and overall service efficiencies. The work to deliver against the standards is being personally led by the Trust's Medical Director working with senior clinical colleagues within the Trust and across the local area.

Alongside the work to deliver internal compliance with these standards, the Trust works actively with the CCG and other partner organisations, to maximise access to urgent care and out-of-hours services in support of hospital-based emergency services. A number of positive developments have been progressed over the last 12 months culminating in a successful bid to establish 'GP Streaming' at Ipswich Hospital. This service will be operational from September 2017, and will allow the Emergency Department to direct appropriate patients to an emergency GP service within the hospital, through peak hours seven days a week.

The Trust is also continuing to work with the CCG and others to extend the range and accessibility of a number of admission avoidance, early intervention and enhanced discharge initiatives. Working with the CCG and the Local Authority, there is agreement to establish a 'Discharge to Assess' service which enables early discharge to community facilities (including home) for patients with conditions that limit mobility (non-weight bearing) or with delirium or other complex conditions.

Overview

Quality

Accountability

The Trust has an Accountability Framework (AF) in place which brings together a range of indicators at a Divisional level. These are then grouped into the Care Quality Commission (CQC) quality domains and a financial score. Monthly meetings are held between the Divisions and the Executive to review performance. Escalation reports are also presented to the Board and relevant sub-committees.

Each Division is given an oversight category based on their performance. These are:

1 Special Measures
2 Rapid Improvement
3 Intervention
4 Standard Oversight
5 High Performer

The examples of intervention under special measures include one or more of the following:

- Financial – Suspension of delegated authority;
- Financial – Director approval of all purchase orders;
- Loss of decision making powers;
- Divisional Board Capability review by Third Party;
- Division Board to Trust Executive, special meeting(s);
- Improvement plan(s) to be approved and monitored by Trust Executive via the AF Oversight meetings or other stated forum;
- Further reviews as needed;
- Any other intervention as determined by the Trust Executive taking into account the specific circumstances triggering this escalation.

Ward-level reports are also produced for safer staffing and quality heat map on a monthly basis, and these are reviewed by the Board.

Sharing our story...

Emergency Therapy Team

Our specialist admission avoidance therapy team which ensures the right support is in place to allow older patients to return home from hospital more quickly has extended its hours.

The Emergency Therapy Team (ETT) now offers an extended service from 8am to 8pm on 365 days a year.

Its aim is to prevent unnecessary hospital admissions while helping to successfully discharge those who have received care and are clinically fit to go home.

Overview

Activity

Activity Planning

A failure to manage activity growth is the single biggest risk to the sustainability of the local health economy. Therefore the Trust has agreed key activity-based objectives which will be delivered with all partners across the health system:

- Create urgent and emergency care pathways which treat patients in the most appropriate place;
- Integrate elective and chronic care pathways so patients only come to hospital when they really need to and all our services are safe, secure and have a sustainable future; and
- Ensure there is appropriate capacity in the right place in the care system.

The Trust and CCG have built a contractual and activity framework based on the following principles:

- The Sustainability and Transformation Plan (STP) provides a framework which ensures financial sustainability for the whole health system;
- Contained within this envelope is a realistic level of affordable growth – c2.5% overall per year; and
- The Trust is undertaking a bottom-up assessment of growth on a specialty-by-specialty level for the purpose of:
  - understanding the key areas of demand which put at risk being able to hold to the principles of the STP;
  - agreeing joint programmes of work with partners to manage down that risk; and
  - agreeing appropriate risk share agreements for managing unplanned changes in demand.

As system partners we all recognise that demand management schemes will be a key focus over the next five years, and already have plans in place to address this:

- Within the STP we are focussing on prevention, self-care and independence, and improved community care;
- We have launched our CAT and FAB admission avoidance schemes, and are currently piloting Discharge to Assess in Felixstowe;
- A business case has been prepared for an Urgent Care Centre on the Ipswich Hospital site which will handle all walk-in activity; and
- A system wide 'One Team' approach is currently focussing on delayed transfers of care.

Within our elective areas we have also developed:

- Revised and integrated pathways for musculoskeletal conditions including a Single Point of Access;
- Pre-referral guidance for GPs continues to be rolled out in a range of specialties – this provides initial treatment plans to attempt before referring, highlights alterative pathways, and ensures an appropriate history is taken with all relevant tests so the patient can be diagnosed at their first attendance;

Sharing our story...

Dementia-friendly wards

Two more wards at our hospital have been transformed into dementia-friendly environments.

Washbrook and Woodbridge ward include social areas for patients, picture signage and colour-coded walls to help patients find their way, improved lighting, decluttered bed areas and calming artwork.

The work was funded by a legacy from a former patient.

Overview

Activity

- Rapid screening clinics in Dermatology – the consultant purely focusses on the diagnosis and can see significantly more patients in a clinic with appropriate support from other clinical staff to start the treatment of the patient; and
- A pilot of the Message Dynamics system as an alternative to follow-up appointments is currently being trialled in two specialties.

A demand management rollout programme has been agreed by the STP which covers:

- general medicine;
- geriatrics;
- phase 2 MSK (T&O, pain, rheumatology);
- cardiology;
- stroke;
- gastroenterology including endoscopy; plus
- a further phase covering general surgery, vascular, breast, ENT, dermatology and A&E.

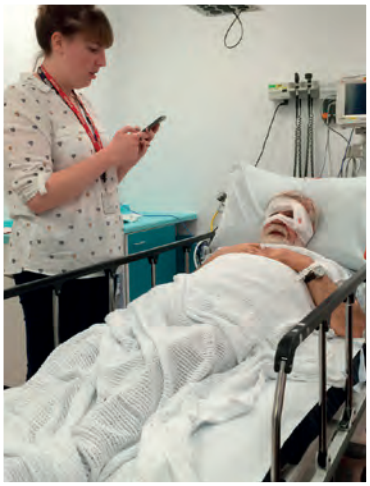
The Trust has placed an intensive focus on recovering our A&E performance. A range of initiatives have been implemented across the department, including listening events and electronic records. However, flow through the hospital remains the main issue with delayed transfers being the key bottleneck, reaching over 1,800 bed days in September and double the number from the same period last year. A recent 'One Team' taskforce, incorporating the Trust, the CCG and Social Care, has been solely focussed on delayed transfers for a three-week period, and significant progress has been made in clearing delays and fully understanding the systematic causes of such delays. The methodology has been so successful it is being considered for other areas of work.

Sharing our story...

24 hours live in the Emergency Department

The national BBC team spent 24 hours in our Emergency Department reporting live.

Staff opened the doors to the journalists and their cameras to give the public a chance to see behind the scenes. Patients featured included a 23-year-old who collapsed during a night out, a boy who pierced his lip with his tooth while playing basketball, a 74-year-old who fell off a train and a lady in her 90s with chest pain.



Overview

Activity

Aside from delivering key operational standards the Trust has set itself the following measures of success for activity and demand management. These are currently in draft form as we complete our strategy consultation:

Metric	Explanation of assumption	2017/18	2018/19	2019/20	2020/21	2021/22	Total
Emergency Admissions	% reduction each year	5%	5%	5%	5%	5%	0%
Outpatient Follow-ups	% reduction each year	15%	15%	15%	15%	0%	52%
Excess Length of Stay (elective)	% of cost of LOS reduced each year	10%	10%	10%	10%	10%	45%
Delayed Transfers of Care	% of cost of DToC reduced each year	20%	20%	20%	20%	20%	74%
Re-admissions	% of cost of readmissions reduced each year	20%	20%	20%	20%	20%	74%

Sharing our story...

Frailty Assessment Base

Our Frailty Assessment Unit team moved into a new dedicated unit.

The award winning team helps frail patients return home quickly and safely while preventing unnecessary admissions.

Performance Analysis

Performance Against Key Indicators

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

Key facts and figures

Births:
3,603

Emergency Department attendances:
87,927

Planned admissions:
7,235 (excluding day cases)
54,089 (including day cases)

Unplanned admissions:
42,802 (including maternity)
35,222 (excluding maternity)

Outpatient attendances:
572,805

Number of appointments people did not attend:
35,495

Diagnostic Imaging examinations (2016 calendar):
235,738

Referrals from GPs and dentists:
101,512

Sharing our story...

Baby friendly award

We've been awarded the prized 'baby friendly' award in recognition of the high standards of care new mothers receive.

The hospital was been given the accreditation by UNICEF (United Nations International Children's Emergency Fund) after we demonstrated that we support breastfeeding and help mothers build a strong relationship with their babies.

Performance Analysis

Performance Against Key Indicators

			Historic Data			
Indicator	**Subsections**	**Threshold**	**Qtr to Jun 16**	**Qtr to Sept 16**	**Qtr to Dec 16**	**Qtr to Mar 17**
From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	YES	YES	YES	YES
All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	YES	YES	YES	NO
	Anti-cancer drug treatments	98%				
	Radiotherapy	94%				
All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	YES	NO	NO	NO
	From NHS Cancer Screening Service referral	90%				
All cancers: 31-day wait from diagnosis to first treatment		96%	YES	YES	YES	YES
Cancer: 2-week wait from referral to date first seen, comprising:	All urgent referrals	93%	NO	YES	YES	YES
	For symptomatic breast patients (cancer not initially suspected)	93%				
A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	NO	NO	NO	NO
Clostridium difficile	Is the Trust below the YTD ceiling	*18*	YES	YES	YES	YES
MRSA	Is the Trust below the YTD ceiling	*0*	YES	YES	YES	YES

Performance Analysis

Operating Financial Review

In 2016/17, the Trust returned a deficit of £17.6m; this is the financial performance against which the organisation is measured, as it excludes non-recurrent costs associated with impairment of assets and non-recurrent grants and charitable fund income net of depreciation. The operating deficit recognising the above was £22.3m. The Trust ended the year £2.5m ahead of the planned deficit of £20.1m; this is a notable outcome in a period of operational pressure and financial challenge across the NHS.

Continuing improvements to financial management across the organisation helped to identify and deliver £11.6m of Cost Improvement efficiencies in-year, £8.2m of these efficiencies are recurrent into future years; the primary aim of these programmes is to deliver sustainable improvements in operational and financial performance across the Trust. Key successes in sustainable improvement during 2016/17 include improved pathways to make better use of resources, reduced reliance on temporary staffing, better procurement. The Trust has been an active participant in the Lord Carter review.

Total income rose in the year by £30.1m (11%) in 2016/17 as a result of increased activity across the year and £7.8m Sustainability & Transformation support. Total expenditure increased by £25.8m, excluding Impairments. The Trust continued with the Guaranteed Income Contract with our lead commissioner, an approach which is helping to underpin the system financial position and supporting the focus across all organisations to the system-wide costs of providing healthcare.

Total Pay increased by £12.4m (8%) through national pay awards, increases in activity as well as the full-year effect of the Community Services contract introduced in October 2015. The Trust reduced total expenditure on agency staffing from £11.4m in 2015/16 to £11.0m in 2016/17 despite increases in activity. Non-pay (excluding impairments) was £14.0m higher (12% year-on-year) in 2016/17 with the increased cost of clinical supplies of £6.3m the primary driver of this increase, linked to increases in the volume of care. As with the majority of trusts, contributions to the national Clinical Negligence Scheme increased in 2016/17 by a value £1.1m for the Trust.

Sharing our story...

Staff commendations

Staff who go above and beyond have been rewarded for their dedication through our Ipswich Commendations scheme.

The awards are given to staff who do something exceptional – such as trainee Dr Foyzur Miah who spent several hours with an anxious family in the Emergency Department and gave them exceptional support.

Performance Analysis

Operating Financial Review

Whilst the financial plan for 2016/17 was delivered, as a consequence of the operating deficit, the Trust was required to secure a loan to underpin cash management in-year; this amounted to £21.9m for 2016/17; total borrowings in the form of loans stand at £48.8m. Cashflow is closely aligned to the underlying financial position of the organisation and will remain as such for the medium-term. The financial position impacted on the 30-day performance of the Trust in 2016/17, with careful management of scarce cash resources remaining a priority all year; the Trust Executive via the Finance & Performance Committee maintains close scrutiny of this across the year.

The Trust invested in total £11.8m in maintaining and developing the asset base during 2016/17, including:

- £0.9m on the Woolverstone Macmillan Centre, which opened in May 2016; the total project came in within budget at £4.7m;
- £0.5m on MRI building works;
- £0.8m on the refurbishment of dementia wards; this vital work was funded through the Peter Gibbons legacy received in 2015/16;
- £3.2m replacing and upgrading medical equipment across the Trust;
- £1.6m backlog maintenance across the Trust;
- £2.2m on enhancing the Trust IT infrastructure;
- £2.6m general site improvements, the most significant of which was the Spinal Surgery Admissions Unit £0.8m.

The financial outlook for the Trust remains very challenging into 2017/18 and beyond; the deficit of £17.6m in the past year was delivered with £7.8m non-recurrent Sustainability & Transformation funding (STF); the planned deficit for 2017/18 is a deficit of £18.1m, again after assuming receipt of £7.1m STF for a further year. The Trust Board has reviewed the financial projection for 2017/18 and believes it to be a credible and appropriate plan, whilst recognising that there is an increased risk profile to the plan linked to a challenging requirement to identify and deliver efficiencies of £15.8m. The Trust financial plan is linked intrinsically to the Trust Strategy 'Writing the Next Chapter'.

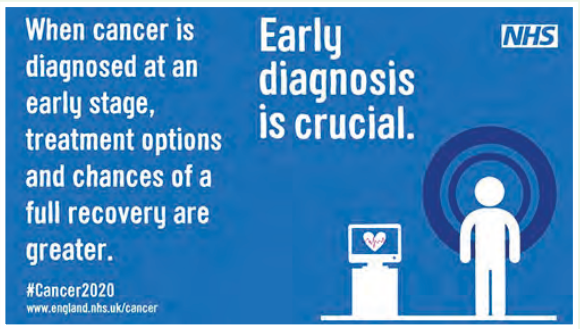
Sharing our story...

Early diagnosis for cancer

Our hospital joined four others across the country to take part in a pilot scheme designed to speed up the diagnosis of cancer.

We are aiming to give a diagnosis or the all clear to 95% of patients under investigation for gynaecological or colorectal cancers.

It is hoped the results can be used to speed up diagnosis for all cancer patients in the country.



Performance Analysis

Our Buildings and Structure

Almost 8,000 people every week day use the hospital. Maintaining and developing the actual hospital environment is the focus of this part of our Annual Report.

Estates Development and Infrastructure Schemes

The role of Estates Development is to support clinical services in their pursuit of perpetual improvement. Services develop and change constantly, and the built environment needs to keep pace. Carrying out building work in live clinical environments is a complex undertaking, and requires very careful planning to ensure everyday care is not disrupted. Over the last 12 months we are very proud to have successfully delivered a number of important projects:

MSK Admissions Unit

This new unit created the opportunity to increase capacity and redesign the pathways for elective orthopaedic patients, enabling further patients from other areas to be treated here. Initial feedback from patients has been very positive. Costing £800k, the self-contained unit was constructed in the old South Gym in just ten weeks.

Frailty Assessment Base

Following the successful 2016 pilot of this new service, an expanded unit was constructed within a former stores area in Main Outpatients at a cost of £400k. The service takes patients from the community and ED referred through the Geriatrician Hotline, providing multidisciplinary assessment for frail patients in order to avoid hospital admission. This service is predicted to prevent over 500 admissions over the next 12 months, saving £600k. This service was also shortlisted for the Health Service Journal award for acute service redesign.

Patient Environment Improvements

Responding to the findings of our 2016 PLACE Assessments (Patient-Led Assessment of the Care Environment) we now have chilled mains-fed drinking water available to every patient on every ward.

Further dementia-friendly improvements were made to all

Sharing our story...

A breath of fresh air

People using our hospital site can now enjoy a breath of fresh air as we've gone tobacco-free.

We have removed smoking shelters and introduced vaping areas for people who want to use e-cigarettes.

Doctors and nurses are hoping it will encourage more people to quit, with support from NHS stop smoking services.

Performance Analysis

Our Buildings and Structure

South Wards in the form of colour-coded doors to assist patients to find their way around the wards.

All the ward kitchens to South Wards have been upgraded this year.

All the ensuite shower rooms to Bramford Ward have been refurbished this year.

Changing Places, Changing Lives

A Changing Places toilet has been constructed within the Main Outpatients department. This brilliant MENCAP-approved facility is appropriate for use by the carers of adults and children with profound and multiple learning disabilities, motor neurone disease, multiple sclerosis, cerebral palsy, as well as older people. This toilet will not only provide a very valuable facility for those visiting the hospital, but ours will join others on a national register enabling carers to plan days out more effectively.

Dementia-friendly Improvements

With the benefit of an enormously generous legacy from Mr Peter Gibbons, two wards were refurbished in 2016 with the emphasis on dementia-friendly environments. Responding to the needs of an aging population, these improvements make our wards feel calm, secure and easier to navigate. During the summer of 2016, Washbrook and Woodbridge wards were refurbished. In 2017 we are planning to refurbish Stradbroke and Brantham Wards.

The MRI Scanners Replacement

This project has seen the replacement of two MRI scanners, and the preparation of space to receive a third machine in the future. This was an enormously complex undertaking, required wholesale remodelling, the redirection of services and structural alterations – all within a functioning diagnostic imaging department. Costing £3 m and taking less than a year to complete, the project helps to meet increasing demand for diagnostic scans.

The Woolverstone Macmillan Centre (WMC)

Commenced in November 2014 and partially funded by Macmillan Cancer Support, the new centre opened in May 2016. The new £4.7 m unit brings together outpatient chemotherapy, oncology and haematology services under one roof in a state-of-the-art facility. The centre has been designed around the patient, featuring treatment bays large enough to allow patients to be accompanied by a loved one – of particular importance for those receiving chemotherapy for hours at a time.

Infrastructure Projects

Behind the scenes our team has worked to improve the sustainability and resilience of hospital services. 100% of the site's electrical supplies are now backed-up by generators, including the installation of complex switching arrangements to allow testing of back-up systems without any noticeable effect on service. Operating theatres have also benefitted from replacement 'uninterruptible power supplies' to ensure continuity of service in the event of power outages. The replacement of aging electrical infrastructure is a constant challenge; and in 2016 we completed the final phase of replacing old distribution boards in Main Outpatients.

Accessibility

As a provider of public healthcare services, the hospital is visited by a high proportion of wheelchair users and others with mobility issues. This year the Trust has completed the final phase of a project to upgrade all its lifts to be fully compliant with modern accessibility requirements. This work continues in 2017 with the roll-out of site-wide access guides to be published online through its engagement with DisabledGo.

Development of the Bridge School Site

The Bridge School site was acquired in 2016 as part of the Trust's strategic estates plan for redevelopment of the site over the next 10 years. The additional land provided will enable our key objective of moving out of the aged buildings at the north end of the site and developing the south end of the site to address clinical adjacencies, construct new clinical areas and improve the patient and staff experience. In 2016 the Trust Board approved the plan to demolish the old school buildings and to use the site temporarily for car parking whilst longer-term plans are being formalised.

Performance Analysis

Our Buildings and Structure

Sustainability

Leadership and Engagement

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

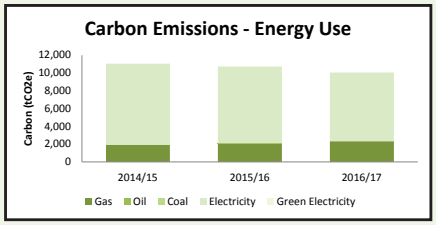
The Trust has achieved some major successes in carbon-saving measures in its buildings, in particular the recent introduction of a new biofuel CHP unit. The Trust is now in a unique position where the majority of both its heating and electricity is produced on site from renewable sources, putting the Trust on track to meet our statutory CO_2e reductions.

However the Trust recognises that there is a need to bring its overall sustainability agenda up to date, and to reflect the new partnership with Colchester Hospital University Foundation Trust. The Trust recruited a new Energy and Sustainability Manager in 2017 to drive the sustainability agenda forward.

The Trust has a Sustainable Development Management Plan (SDMP) which will be revised in 2017/18 to define more specific targets and measurable outcomes. The Trust is exploring using the NHS Good Corporate Citizen (GCC) model to measure its performance and to set a framework for improvement.

Resource		2014/15	2015/16	2016/17
Gas	Use (kWh)	9,217,290	9,894,833	11,154,253
	tCO_2e	1,934	2,071	2,331
Oil	Use (kWh)	0	121,000	0
	tCO_2e	0	39	0
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
"Steam (waste->energy)"	Use (kWh)	15,132,904	12,068,500	14,371,500
	tCO_2e	0	0	0
Electricity	Use (kWh)	14,707,497	14,997,997	14,947,149
	tCO_2e	9,109	8,623	7,725
Green Electricity	Use (kWh)	0	0	441,766
	tCO_2e	0	0	0
Total Energy CO_2e		11,043	10,732	10,056

Water		2014/15	2015/16	2016/17
Mains	m3	136,205	154,459	160,834
	tCO2e	124	141	146



Resources:

Energy and Water

Energy consumption increased in 2016/17 in line with increased footfall and colder weather, but carbon emissions decreased slightly thanks to a reduction in the carbon content of grid electricity – and thanks to some successful test-running of the new Biofuel CHP unit.

Water consumption slightly increased in 2016/17 despite the impact of water-saving measures introduced in partnership with Anglian Water.

Renewable Energy – Biofuel

In April 2017 the new on-site biofuel CHP unit was brought on line. This innovative scheme burns used cooking oil (which would otherwise go to waste) to generate renewable electricity which is used by the Hospital. This greatly reduces the amount of grid electricity used by the Hospital, and will make significant reductions to the Trust's carbon emissions as well as energy costs from 2017/18 onward.

Renewable Energy – Waste

100% of our clinical waste is incinerated on site and the heat recovered is used to heat the hospital, meaning much less gas is used than at other hospitals. This reduces our carbon emissions by more than 1,100 tonnes.

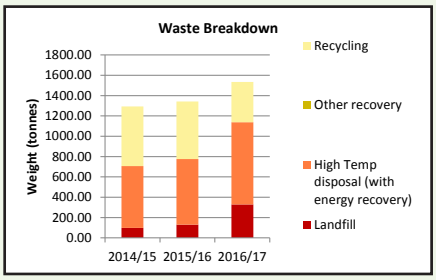
Performance Analysis

Our Buildings and Structure

Waste		2014/15	2015/16	2016/17
Recycling	(tonnes)	586.13	565.65	396.22
	tCO_2e	12.31	11.31	8.32
Other recovery	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
High Temp disposal (with energy recovery)	(tonnes)	608.38	646.45	809.45
	tCO_2e	12.78	12.93	17.00
Landfill	(tonnes)	98.23	130.00	328.90
	tCO_2e	24.01	31.77	101.96
Total Waste (tonnes)		1292.74	1342.10	1534.57
% Recycled or Re-used		45%	42%	26%
Total Waste tCO_2e		49.09	56.02	127.28

Waste

Our total waste production increased in 2016/17, this was largely accounted for by increased production of clinical waste, which is incinerated on site with heat recovery.



Our recycling proportion decreased during the year due to technical issues with the materials reclamation facility, these have now been resolved and normal recycling has been resumed.

Travel

The Trust received a higher response rate to its staff travel survey in 2016. The Trust's Travel Plan was recently updated and identifies an action plan to deliver increased usage of public transport and greater uptake of walking/cycling, including the implementation of personal travel plans.

Procurement

The Estates and Facilities department works closely with ISS, its Hotel Services partners, on a number of sustainability initiatives as part of its contract with Ipswich Hospital with progress in the following areas:

- ISS retail catering achieved Soil Association Bronze award as part of 'Food for Life', relating to sustainable foodstuffs;
- food waste is now sent off site for anaerobic digestion and electricity production;
- on-site security vehicle is fully electric.

Hotel Services Joint Procurement

In December 2016, the Boards of both Colchester and Ipswich Trusts approved the joint procurement of hotel services and laundry services in one of the largest pieces of joint working between the Trusts to date.

Benefits expected to flow from this joint procurement are:

- a sharing of best practice from both Trusts improving patient care and experience;
- financial benefits from volume purchasing and VAT savings available from contracting a fully managed service;
- an increased compliance with efficiency standards and benchmarks set by NHS Improvement and the Department of Health.

Input to the new specifications has been provided by patient representatives, staff and subject matter experts to ensure that the new contract is fit for purpose.

An integrated project management and delivery team is working through the procurement process and is on track to deliver the start of the new contract in April 2018.

Fire Safety

Throughout the year Fire Safety has played a significant role in the work plans within the estates department.

The Trust has undertaken substantial surveying and inspections to assure ourselves of our fire safety position and continued to improve passive fire protection during ward refurbishments, further reducing our risk through enhancing and upgrading our fire alarm panels.

Performance Analysis

Our Buildings and Structure

Other initiatives include improvement of our maintenance programmes for fire damper testing and fixed wire testing.

Along with this work we have twice been visited by the Suffolk Fire Service. During these visits we have reviewed our policies and strategies with their representatives and they have provided positive feedback about the plans and structures we have in place.

Security

In the past year we have continued with our upgrade of the CCTV recording system improving its ease of use by streamlining the technology.

We have supported our colleagues from Suffolk Constabulary on numerous occasions including providing vital CCTV evidence to support criminal investigations and prosecutions.

In the past 12 months there were 176 security-related incidents reported, of which 88 were either physical or verbal assaults on staff, 35 relate to theft from Trust, staff and patients, 15 related to impacts from medication and the remaining 38 fall under other incidents, which is a mixture of nuisance behaviour/vagrancy type incidents.

Emergency Planning

Ipswich Hospital continued to maintain its fully compliant status in line with NHS England core standards of Emergency Planning Resilience and Response and our duties as a category 1 responder under the Civil Contingencies Act 2004.

During the year the Trust participated in various exercises to test system-wide resilience not only in health but also supporting our colleagues in other emergency services and local industries.

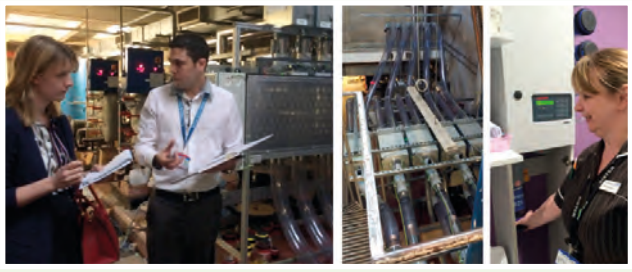
The largest exercise of this kind in which we participated saw the Trust, along with 29 other acute Trusts from across the midlands and eastern regions, working with representatives from the Midlands and East of England Ambulance Trusts, NHS England, and UK and US Military.

It was designed to test system resilience in the face of a mass casualty event. The purpose of these exercises and learning opportunities was realised towards the end of 2016 when the Trust was involved in one significant, one critical and one major incident within a two-month period.

Our well-rehearsed plans and excellent team demonstrated our resilience and the good working relationships we have fostered with colleagues in other emergency services and the wider health and community infrastructure ensured the appropriate responses in the correct timeframe and led to the right outcome.

Sharing our story...

Quicker ward deliveries



Doctors, nurses and their teams can now send medication and samples across our hospital faster than ever before following a £180,000 upgrade of the pneumatic 'whoosh tube' delivery system.

The hospital has new state-of-the-art technology. Similar to the pneumatic systems seen in supermarkets, it uses air suction and pressure to send carriers along a network of tubes to specific wards or departments, such as the pharmacy or pathology lab.

The whoosh tube can securely direct drugs or samples from one end of the hospital to the other in just two minutes or less, saving a significant amount of time for staff.

Accountability Report

Corporate Governance Report

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 five Executive Directors. The Trust also has one Associate Non-executive Director.

Chair and Non-executives – at 31 March 2017	
David White	Chair
Tony Thompson	Non-executive Director
Andrew George	Non-executive Director
Laurence Collins	Non-executive Director
Richard Kearton	Non-executive Director (from December 2016. Associate Non-Executive Director from May 2016 to November 2016).
Helen Taylor	Non-executive Director (from April 2016)
Elaine Noske	Associate Non-executive Director (from May 2016)

Alan Bateman was a Non-executive Director until December 2016.

All Non-executive Director appointments are made through the NHS Trust Development Authority, which from 01 April 2016 has joined with Monitor to become NHS Improvement.

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

Membership of the Audit Committee comprises three Non-executives. The Chief Executive and Director of Finance and Performance usually attend each meeting as well as external and internal auditors.

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

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

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

The Chief Executive and Executive Directors were appointed using open competition and a selection process. They were appointed on a permanent basis. All are subject to annual performance reviews and all usual Trust policies and procedures.

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

Details of directors' remuneration are given on page 53 of this report.

Corporate Governance Report

Directors' Report

Composition of the Management Board

We place clinicians at the centre of the hospital's leadership. 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 Executive Management Committee) contributes to and implements Board, Executive and clinical team decisions.

Trust Executive Directors – at 31 March 2017	
Nick Hulme	Chief Executive
Neill Moloney	Managing Director
Martin Mansfield	Interim Medical Director
Lisa Nobes	Director of Nursing
Paul Scott	Director of Finance and Performance
Rupert Wainwright*	Interim Director of Operations
Clare Edmondson*	Director of Human Resources
Paul Fenton*	Director of Estates
Denver Greenhalgh*	Director of Governance

** Non-voting Board member*

Dr Barbara Buckley was Medical Director until November 2016.

Sharing our story...

Year of specialist Fertility care

Our fertility service is growing and offering more options to local people wanting to plan or start a family.

We've partnerships with two of the country's leading fertility centres in Cambridge and London. The partnerships allow our doctors to offer a satellite IVF service giving patients the chance to start treatment at Ipswich and go on to have egg collection and embryo transfer at one of the specialist centres.

Corporate Governance Report

Directors' Report

Declaration of Interests

Declaration of Interests 1 April 2016 to 31 March 2017	
David White Chair	• Chair – Colchester Hospital University NHS Foundation Trust • Non-executive director – Bullen Developments Ltd
Alan Bateman Non-executive Director (Left Trust December 2016)	• Paid employee – Sailstone Ltd
Laurence Collins Non-executive Director	• Governor – Rushmere Hall Primary School, Ipswich
Andrew George Non-executive Director	• Director – Suffolk Mind • Independent person – Various councils in Suffolk • Interest in a property syndicate (offices in Diss and Eye)
Tony Thompson Non-executive Director	• Trustee – Melton Trust • Paid employee – Tony Thompson Associates Ltd
Helen Taylor Non-executive Director (From April 2016)	• Nil
Richard Kearton Non-executive Director (From April 2016)	• Consultant at GU Consulting • Consultant at Judy Oliver Consulting
Elaine Noske Associate Non-executive Director (From May 2016)	• Paid employee – BT
Nick Hulme Chief Executive	• Chief Executive – Colchester Hospital University NHS Foundation Trust • Member – Kettleburgh Parish Council • Wife is a Trustee of Suffolk Family Carers
Paul Scott Director of Finance and Performance	• Nil
Neill Moloney Managing Director (From July 2016)	• Nil
Barbara Buckley Medical Director (Left Trust November 2016)	• Husband is a GP in North London
Martin Mansfield Interim Medical Director (From May 2016)	• Nil
Clare Edmondson Director of Human Resources	• Nil
Lisa Nobes Director of Nursing	• Nil
Paul Fenton Director of Estates	• National Chairman of the Health Estates and Facilities Management Association (HEFMA)
Rupert Wainwright Interim Director of Operations (From January 2017)	• Shareholder and employee of Zenon Consulting Ltd
Denver Greenhalgh Director of Governance	• Nil
Ann Alderton Company Secretary	• Company Secretary – Colchester Hospital University NHS Foundation Trust • Husband is a Manager at West Suffolk Hospital NHS Trust • Shareholder and Managing Director – Tredaran Consulting Ltd

Corporate Governance Report

Directors' Report

Research and Development Strategy

Our aim is to embed the management of research and innovation within normal Trust business, to set up and recruit patients faster and more effectively and to drive local partnerships and high calibre collaborations between the Trust and universities. 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 Quality Committee. Each division has a monthly Risk and Governance meeting where the groups have a vital role in bringing change, and considering clinical developments, service improvements, risk management and internal control issues throughout the Trust. The Trust complies with the clinical governance reporting framework issued in November 2002.

Emergency Preparedness/ Major Incident Planning

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

Listening and Learning

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

We aim to respond to complaints within 28 working days from receiving the complaint. This year 100% of complaints received were responded to in 28 working days

Sharing our story...

Charity news

The Ipswich Hospital Charity raises money to improve facilities, fund new equipment, provide important additional services, support staff development and initiate local medical research projects. Fundraising events over the past year have included a 13,000ft skydive and a Suffolk villages bike ride.

Corporate Governance Report

Directors' Report

or a revised timescale agreed with the complainant, against a Trust target of 100%. Every effort is made to contact each complainant within 24 hours of the complaint being logged by the complaints team. These calls, known as 24-hour courtesy calls, are made by a senior manager and are seen as an opportunity to:

- gain insight to understand the key issues that need to be resolved;
- take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response;
- explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter or a face-to-face meeting;
- help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously.

All complaints are assigned to a complaints coordinator who will liaise with the complainant and ensure the department responsible for investigating and responding to a complaint does so within the agreed time limits. Once a complaint investigation has been completed, it is checked to ensure all issues raised have been answered, before being passed to a member of the Executive team to review and sign the letter of response.

Reopened Complaints

During the year 2016/17, 28 (5%) of the complaints received were reopened. One of the main reasons for reopening a complaint has been identified as poor or inaccurate investigation. To address this, the Trust has developed a more robust process for ensuring all matters raised within a complaint are adequately addressed. The Trust has a process whereby each reopened complaint is reviewed and where necessary, a Non-executive Director is involved in the subsequent investigation.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

During the year 2016/17, eight cases were investigated by the Ombudsman as the complainant was unhappy with the response received from the Trust. Of these, two cases are still being investigated, five cases were not upheld and one case was partially upheld.

Improvements to Complaints Handling

Following the feedback from the Complaints Survey undertaken in 2014, following which a number of changes were implemented, we now undertake an annual survey of 100 complainants to understand theri experience of the complaints procedure and make changes to our processes where appropriate.

PALS

The PALS team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. This is seen as a positive step towards taking more responsibility for issues as they arise.

PALS contacts are graded as either PALS 1 or PALS 2. PALS 1 are contacts that require straightforward information or signposting. PALS 2 are contacts that relate to a matter which needs to be resolved or addressed.

PALS offers patients, carers and visitors:

- advice and signposting – helping to navigate the hospital and its services;
- compliments and comments – PALS can pass on compliments and ideas to improve services; and
- PALS can address a non-complex issue informally, often preventing a formal complaint being raised.

Typical matters raised with PALS include:

- patients being unable to contact clinics by telephone;
- patients chasing test results;
- patients chasing appointments;
- families or carers raising concerns regarding elements of inpatient care;
- messages left not being returned.

For more information about the complaints we received during last year, please refer to our Quality Account 2016/ 17, which is available on our website.

Corporate Governance Report

Directors' Report

Serious Incidents Requiring Investigation

Reporting incidents helps us to learn from them and decide whether we need to change the way we do things to improve patient safety, as well as identifying areas where we need to focus resources, such as training. We report our patient safety incidents to the National Reporting and Learning System (NRLS) so that information can be reviewed nationally for trends or problems.

Serious Incidents Requiring Investigation (SIRIs)

Adverse Events and SIRIs Reported

For the year 2016/17, there have been the following adverse events (categorised as low harm to severe harm) reported on the Datix risk management computer system. The adverse events recorded below are all adverse events, not only those related to patients.

Type of adverse event	Number of adverse events
Abusive, violent, disruptive or self-harming behaviour	265
Access, Appointment, Admission, Transfer, Discharge	1,564
Accident that may result in personal injury	2,219
Anaesthesia	13
Clinical assessment (investigations, images and lab tests)	432
Consent, Confidentiality or Communication	282
Diagnosis, failed or delayed	58
Financial loss	7
Implementation of care or ongoing monitoring/review	2,634
Infrastructure or resources (staffing, facilities, environment)	330
Labour or Delivery	432
Medical device/equipment	330
Medication	1,166
Other - please specify in description	252
Patient Information (records, documents, test results, scans)	470
Security	63
Treatment, procedure	231
Totals:	**10,748**

Of these incidents, 87 were reported as Serious Incidents Requiring Investigation (SIRIs) on the national Strategic Executive Information System (StEIS):

Type of adverse event	Number of SIRIs
Adverse media coverage or public concern	2
Allegation against staff	2
Diagnostic incident including delay meeting SI criteria	12
Infection control incident meeting SI criteria	5
Information Governance breach	4
Maternity/Obstetric incident meeting SI criteria (mother/baby)	6
Medication incident meeting SI criteria	4
Pressure ulcers Grade 3 or 4	22
Screening issues meeting SI criteria	1
Slip/trip/fall meeting SI criteria	16
Suboptimal care of the deteriorating patient meeting SI criteria	3
Surgical/Invasive procedure incident meeting SI criteria	5
Treatment delay meeting SI criteria	5
Totals:	**87**

Corporate Governance Report

Directors' Report

Learning from incidents

All reported incidents are investigated and lessons that can be learnt are shared by Clinical Delivery Group governance meetings, at Divisional Board meetings, at morbidity & mortality meetings and discussed at the Trust's Risk Oversight Committee.

It is important that when serious incidents occur, they are reported and investigated in a timely manner, not only to ensure that the correct action can be taken, but to enable the Trust to learn from the incident to prevent it happening again and to reassure the patient involved that such incidents are taken seriously and thoroughly investigated.

The higher level incidents are categorised as Serious Incidents Requiring Investigation (SIRIs) and are reported to the Ipswich & East Suffolk Clinical Commissioning Group. These incidents are investigated, a comprehensive report written and actions implemented and the learning shared both within the organisation and with the patient and/or their family.

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 in our Quality Account.

The changes we have made as a result of lessons learnt:

- Information on the management of the febrile child has been added to the induction programme for staff in the Paediatric Emergency Department.
- Safety checklists written for a range of procedures carried out within and outside of the theatre environment to ensure every step of the patient pathway is checked as being correct, in line with NatSSIPs national guidance.
- New cleaning processes and procedures put in place at Felixstowe Community Hospital to prevent the spread of infection.
- Small swabs have been removed from delivery and suture packs and replaced with larger 30cm x 30cm swabs to prevent these being unintentionally retained.
- Processes around safe dispensing of medication on discharge have been revised.
- Introduction of an additional 'time out' check to allow the theatre team to verify the implant to be used for example during joint replacement surgery.
- Introduction of the use of nationally recognised assessment tools for patients who require anticoagulation therapy but have a high risk of stroke.
- Allocation of a family liaison officer to act as a key point of contact and advocate for patients during a SIRI investigation.

Duty of candour

Open and honest communication with patients is at the heart of healthcare.

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

As part of the Trust's process, patients or their relatives are informed of any such incidents. The Trust continues to work to improve the timeliness of follow up letters to patients, their families or carers.

Failure to meet this regulatory standard may result in financial penalty. The Trust has not been subject to any penalties relating to Duty of Candour.

What are we doing to make improvements?

- Design and then make available a patient information leaflet to be given to patients or their relatives who have been the subject of a serious incident (SIRI). The leaflet explains the process for investigating a SIRI and how patients and their families can get involved.

Corporate Governance Report

Directors' Report

Never Events

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

The list of Never Events for 2016/17 are:

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post procedure
- Mis-selection of a strong potassium containing solution
- Wrong route administration of medication
- Overdose of insulin due to abbreviations or incorrect device
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation
- Failure to install functional collapsible shower or curtain rails
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients

There are exclusions to each Never Event.

Never Events at The Ipswich Hospital NHS Trust

2014/15	2015/16	2016/17
3	5	4

Regrettably, four Never Events occurred in 2016/17:

- Retained foreign object post-procedure
- Wrong implant/prosthesis
- Overdose of methotrexate for non-cancer treatment
- Retained swab

Safety Thermometer

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

Corporate Governance Report

Directors' Report

Surgical Safety Checklist – National Standards for Invasive Procedures

In 2016, following a review of national and local learning from the analysis of Never Events, Serious Incidents and near misses, NHS England developed National Safety Standards for Invasive Procedures (NatSSIPs), built on the good work around the World Health Organisation (WHO) Surgical Safety Checklist. NatSSIPs are designed to help organisations provide safe care to patients undergoing invasive procedures in any healthcare setting, not just in the operating theatre.

Last year the WHO Surgical Safety Checklist review group was renamed Safer Invasive Procedure Oversight group, broadening its remit as a result of the new recommendations from NHS England. The group has overseen the review of a new policy on Safer Invasive Procedures, and of clinical areas where invasive procedures are undertaken to ensure local standards of safe practice are applied. The group also oversees the modification of Safety Checklists based on feedback from serious incident investigations.

Going forward the work within our Divisions will continue to incorporate these national recommendations in clinical practice and to provide assurance audits of compliance and quality of application, in order to maintain a safe environment for patients undergoing invasive procedures wherever they take place within the Trust.

Prompt Payment Code

The Prompt Payment Code is a payment initiative developed by Government with the Institute of Credit Management (ICM) to "tackle the crucial issue of late payment and help small businesses."

Details of the code can be found at www.promptpaymentcode.org.uk

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

Details of the Trust's performance against the Better Payments Practice code are disclosed in note 7.1 to the accounts.

Charging for Information

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

Corporate Governance Report

Statement of Directors' Responsibilities

Directors' Statement of Disclosure to Auditors

The Directors at Ipswich Hospital NHS Trust are not aware that there is any relevant audit information of which the NHS Trust's auditor is unaware. The Directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS Trust's auditor is aware of that information. 'Relevant audit information' means information needed by the NHS Trust's auditor in connection with preparing their report.

The Directors have taken all the steps that they ought to have taken as directors in order to do the things mentioned above. They have made such enquiries of their fellow Directors and of the Trust's auditors for that purpose and taken such other steps (if any) for that purpose, as are required by their duties as Directors of the Trust to exercise reasonable care, skill and diligence.

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgments and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Date: 30/5/17

Chief Executive:

Date: 30/5/17

Director of Finance:

Corporate Governance Report

Statement of Accountable Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

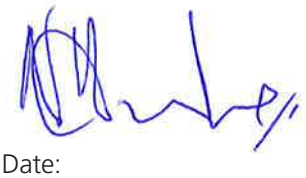
I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:



Date:
30 May 2017

Corporate Governance Report

Governance Statement

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with responsibilities assigned to me in the Accountable Officer Memorandum. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. The Trust has considered the arrangements in place for the discharge of statutory functions and they have been checked for irregularities, and can confirm the Trust is legally compliant.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Ipswich Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Ipswich Hospital NHS Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Chief Executive, I am accountable for the overall risk management activity within the Trust. In discharging these responsibilities I have been assisted by the following Directors:

- the Managing Director (Chief Operating Officer to November 2016) and Deputy Chief Executive, who is responsible for managing risks relating to the day-to-day management of the Trust and those relating to the implementation of corporate strategies and business plans. In addition to his own risk management responsibilities, he oversees the coordination and prioritisation of all risks reported to him from his Trust Executive colleagues;
- the Director of Finance, Performance and Strategy who is responsible for managing the Trust's principal risks relating to the delivery of financial plans agreed by the Board;
- the Director of Nursing who is responsible for managing the principal risks relating to infection control as Director of Infection Prevention and Control; and, with the Medical Director, for managing the strategic development and implementation of safety and quality, for reporting this to the Board, through the Quality Committee, and for the assessment and reporting of clinical risk;
- the Director of Operations who is responsible for managing the Trust's risks relating to operational performance;
- the Director of Human Resources who is responsible for managing the Trust's principal risks related to Workforce Planning;
- the Chief Information Officer who is responsible for the Trust's Information Systems, Security and Governance arrangements;
- the Director of Governance, who is responsible for ensuring that the Risk Policy is implemented and evaluated effectively; and
- the Director of Estates, who is responsible for the safety of the Trust's premises.

A complete description of the responsibilities, accountabilities and duties for risk management is given in the Trust Risk Management Policy.

Corporate Governance Report

Governance Statement

The Trust Governance Framework

The Trust's corporate governance structure is designed to ensure appropriate oversight and scrutiny and to ensure good corporate governance practice is followed.

Trust Board

The Trust Board is comprised of a Chair, five non-executive director members, one associate non-executive director and five executive director members: the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Performance and Strategy, and Managing Director (Chief Operating Officer until November 2016). Four other executive director members without voting rights attend each Trust Board meeting: the Director of Operations, the Director of Human Resources, the Director of Governance and the Director of Estates (from January 2017). The Chief Information Officer will also be attending Board meetings from May 2017. The Chair has a second and casting vote. The Company Secretary (from September 2016) also attended all Board meetings. The Deputy Chair acts as Senior Independent Director.

The Board met a total of six times in public in 2016/17 with private Boards in the intervening months. Attendance was monitored throughout the year and there were 12 absences by a Non-executive during this period and 8 from Executives. All Board members completed the annual declaration for Fit and Proper Person's Test, with the 2016/17 declaration to be reported to the first Public Trust Board in July 2017. The Board's Register of Interests was updated in May 2016 and it was formally received by the Trust. A further review was presented at the March 2017 Board.

There are six Committees of the Board:

Audit Committee

In line with the requirements of the NHS Audit Committee Handbook and the NHS Codes of Conduct and NHS Code of Accountability, the Audit Committee has provided the Trust Board with an independent and objective review of its financial systems, financial information, systems of internal control and regulations governing the NHS. The Trust is not required to comply with the UK Corporate Governance Code but its Corporate Governance arrangements draws on best available practice considered being relevant to the Trust.

The Audit Committee's membership is drawn exclusively from independent non-executive directors and has been supported by the work programmes of internal and external audit. This ensures independence from executive and operational management.

The Chief Executive, Managing Director, Director of Finance, Performance and Strategy, Director of Governance, Company 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 met on six occasions during 2016/17 and provided independent monitoring and scrutiny of the processes implemented in relation to governance, risk and internal control. The Committee has reported its proceedings to the Trust Board following each meeting.

Quality Committee

The Quality Committee has delegated authority to assure the ongoing development and delivery of the Trust's safety and quality priorities and the safety and quality of services provided.

It has been supported by the work of the Executive safety and quality committees (Patient Safety & Effectiveness, Patient & Carer Experience and Trust Safety) and reports from safety and quality leads.

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

Finance and Performance Committee

The Finance and Performance Committee has provided assurance to the Trust Board in the following areas: strategic financial and contractual performance matters; delivery of in-year financial plans

Corporate Governance Report

Governance Statement

and cost improvement plans; the Trust's financial policies; long-term financial sustainability, and capital investment.

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

Nomination and Remuneration Committee

The Nomination and Remuneration Committee's role is to appoint, and, if necessary, dismiss the executive directors; establish and monitor the level and structure and reward of the Chief Executive and executive directors (subject, where applicable, to Treasury approval via NHS Improvement), ensuring transparency and fairness and consistency; develop and implement succession planning for key senior management posts; ensure that contractual terms on termination and any payments in respect of executive directors are lawful and represent value for money; and ensure all provisions regarding disclosure of remuneration, including pensions are fulfilled.

The Committee also has responsibility for assurance around the Fit and Proper Persons test for Board Directors, Non-executive and Executive.

Charitable Funds and Sponsorship Committee

The Trust is also the corporate trustee of the Ipswich Hospital NHS Trust Charitable Fund (Registered Charity 1048827), which is overseen by the Charitable Funds and Sponsorship Committee, which is a Committee of the Board. The Board met as corporate trustee to approve the Ipswich Hospital charitable funds annual report and accounts for the year ended 31 March 2016, to approve the Letter of Representation and to receive the ISA2260 report from the external auditors.

Workforce, Development and Education Committee

Established as a committee of the Board in April 2016, the Workforce, Development and Education Committee provides assurance to the Board on issues relating to workforce, organisational development and education. Chaired by a Non-executive Director, the committee reports on key issues to the Board after every meeting.

Board Effectiveness Review

The previous external diagnostic of board and quality governance arrangements took place in 2014/15. The structure used for this review was the Well-led framework: Guidance for NHS Foundation Trusts, which remains the main evaluation tool in use in the NHS for assessing board effectiveness. As at 2016/17, all of the matters arising from this evaluation had been implemented.

The Board has referred to and will continue to review its performance against the criteria in the Well-led framework to reflect on its composition, effectiveness, risk management and internal control arrangements and is satisfied that it complies with corporate governance best practice.

In 2016/17 the Board has met on a bi-monthly basis to enable more in-depth review of topics and to develop strategy and has undertaken a range of development activities with regular seminar time scheduled into its work programme. This time is used to ensure the board are 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, such as the transition into an integrated care organisation and the potential long-term partnership with Colchester Hospital University NHS Foundation Trust.

During the year the Trust has continued to review the effectiveness of the operating model. Contributions from the leadership tiers across the organisation, including the Board, are used to identify the strengths, weaknesses and further opportunities for improved effectiveness.

All Board Committee terms of references were reviewed by the Board in March 2017 in accordance with the governance review recommendations and will be ratified within the Trust's Corporate Governance Framework along with the Standing Orders, Schedule of Matters Reserved to the Board, Standing Financial Instructions and the Scheme of Delegation during 2017/18.

Corporate Governance Report

Governance Statement

Executive Oversight of Risk Framework

The day-to-day management of the Trust is managed by three clinical divisions. Each division has its own leadership team and divisional board chaired by the Clinical Director, with an Associate Director of Nursing, and Head of Operations making up the triumvirate leadership that mirrors the composition of the Trust Board. They are supported by the Corporate Division for Human Resources, Finance, IT and Estates expertise.

The Trust continues to empower the division accountability 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. This structure continues to secure the engagement of clinicians including doctors, nurses, midwives and allied healthcare professionals in the leadership of the organisation through an accountability framework.

Oversight, challenge and scrutiny of divisional risks is undertaken monthly at the Risk Oversight Committee which has Executive members and Non-executive Director attendance.

The divisional leaderships and the executive directors meet monthly as an Executive Management Committee, which is responsible for ensuring the risks on the corporate risk register and Board Assurance Framework are managed. The committee submits a highlight report of the key issues to the Board.

Quality Governance

Whistleblowing and Speaking Up

The Trust encourages staff to speak up about any concerns at work. The Board considers it to be a vital way in which the organisation learns and continues to improve services for our patients and the working environment for our staff.

In accordance with our duty of candour, the Board and leadership team are committed to providing an open and honest culture. In December 2016, a Freedom to Speak Up Guardian was appointed jointly with Colchester Hospital University NHS Foundation Trust, to help raise the profile of raising concerns and to provide confidential advice and support to staff who wish to raise concerns or have issues about the way their concern has been handled. Underpinning this, a range of processes and interventions are in place to enable staff to report concerns promptly and to be supported in doing so, without fear of reprisal. This includes a standard integrated policy as recommended in the review by Sir Robert Francis into whistleblowing in the NHS, which was published on 01 April 2016. All of this will help to strengthen our approach to raising concerns for the benefit of all patients.

Serious Incidents

All Board members are notified of Serious Incidents, high level complaints and clinical claims. The Trust reports all serious incidents and never events in line with the national and local frameworks.

There were four never events during 2016/17. These related to a retained foreign object post procedure, wrong implant or prosthesis, an overdose of methotrexate for non-cancer treatment and a retained swab. All of these never events have been investigated and closed by the Clinical Commissioning Group. There is a system in place to monitor implementation and compliance and any outstanding actions are reported through the Accountability Framework.

The Trust has in place a policy for the implementation of Duty of Candour regulations and is able to evidence this being achieved in respects to being open with patients, their families and carers when things have happening giving rise to patient harm; however further work is being done to deliver this consistently within the contractual requirement to send follow-up letters within 10 days.

The Board receives a monthly report detailing all serious incidents, never events, high level complaints and claims which include lessons learned and actions being taken from investigations completed.

Clinical Audit

The Trust has in place a Patient Safety and Clinical Effectiveness Group which oversees and ensures that there is a programme of

Corporate Governance Report

Governance Statement

clinical audit activity within the Trust covering a range of clinical standards. This group oversees that the Trust has mechanisms in place to implement the latest guidance and recommendations from NICE and relevant National Confidential Enquiries and reports to the Quality Committee.

During 2016/17, the Trust participated in three national confidential enquiries and 31 clinical audits, a full list of which is reported in the Quality Account, along with a sample of outcomes from local audits.

The Patient Safety and Clinical Effectiveness Group monitors audit activity to ensure that the overall objectives are met and complies with professional good practice, current legislation, national policies and guidelines.

Quality Accounts

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Quality Accounts have been prepared, and at this time are unaudited. The Quality Committee has reviewed a draft and the external auditors will present their report to a future meeting of the Audit Committee.

Care Quality Commission (CQC) Registration

The Care Quality Commission (CQC) did not conduct any visits announced or unannounced in 2016/17.

The previous CQC hospital inspection took place in January 2015 and was reported to the Trust in April 2015. The inspection rated the hospital as 'Good'.

The action plan to address the issues raised by the CQC has been fully implemented, but the Trust continues to champion continuous improvement across all divisions and departments.

Risk Assessment

Risk Management Policy

The Risk Management Policy and supporting policies and procedures set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled.

Risk Management Training

The Trust requirements for risk management training are described in the Mandatory Training Policy.

Risk Management, Board Assurance Framework and key risks

Risk management is taken into account in the organisation in a variety of ways. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. Local clinical delivery groups (CDGs) develop and maintain local risk registers and oversee the management of adverse incidents. Risk processes are monitored and reviewed by the monthly Risk Oversight Committee meeting, Executive Management Committee, Quality Committee, Finance and Performance Committee, Workforce Development and Education Committee and Audit Committee.

Board Assurance Framework (BAF)

The BAF provides the Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of principal objectives are at risk due to a gap in control and/or assurance.

Each risk has an identified risk owner who is responsible for managing and reporting on the overall risk. The identified risk owner is an Executive, or other, Director. An assurance committee is also identified to assure the Board that each principal risk is being monitored, gaps in controls identified, and processes put in place to minimise the risk to the Trust.

The designated Assurance Committees of the Board are the Quality Committee (Clinical Risk) and the Finance and Performance Committee (Financial and Contractual Performance) and Workforce, Development and Education Committee (Workforce Risk). The Audit Committee monitors the risk management process overall.

Risks scoring 15 and above migrate to the Board Assurance Framework (BAF), as such nine risks were identified with a net severity of 15+. For each of the risks (detailed below) the BAF described the processes and controls in place to manage the risk, and what further action is necessary to control the risk. The BAF is reviewed quarterly

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at a public Board meeting and the risks scoring 15+ at each public Board meeting. The risks escalated during 2016/17 included the following:

- Risk of insufficient capacity to meet local activity growth in excess of contract assumptions, impacting on ability to assess and treat people in a timely manner;
- Risk of insufficient capacity, skills and abilities in the area of transformational management to realise the benefits within the Trust's STP portfolio;
- Inability to plan for financial sustainability through transformation may impact on service delivery, contractual performance, delivery of Trust strategy and regulator intervention in the long term;
- Inability to resource nurse and Allied Health Professionals (AHPs) staffing rotas at ward level, impacting on ability to meet patient needs consistently;
- Inability to resource our medical rotas, impacting on ability to meet patient needs consistently;
- Failure to carry out surveys of fire compartmentation (at the Ipswich Hospital site) may result in the Trust having insufficient assurance on the effectiveness of these barriers for fire containments, impacting on conformance with fire safety regulations;
- Failure to recognise and manage suspected sepsis in a timetly manner, impacting patient outcomes;
- Failure to carry out risk assessments to support the use of non-safe sharps may lead to unsafe practice and non-compliance with legislation, resulting in regulatory sanctions;
- Potential delays in RTT and achieving 18-week performance within Division 2 due to forecast capacity constraints and the impact of bed pressures.

In March 2017 there were seven high level risks remaining on the corporate risk register.

Risk and Control Framework

The Trust responsibilities and accountabilities for risk management are described in the Trust risk management policy.

Performance Against National Priorities

The Trust Integrated Performance Report (IPR) is reported to the Trust Board at each of its public meetings. The IPR brings together key metrics used by NHS Improvement, NHS England and Commissioners in evaluating Trust performance.

During 2016/17 the Trust has demonstrated satisfactory performance against some of the key performance indicators. Key achievements this year include:

- Compliance with the 18-week incomplete pathway threshold of 92% across the year at a Trust level of 94.6%;
- Compliance with the Cancer 31-day target throughout the year;
- Achievement of the Trust MRSA trajectory reporting zero cases in year;
- Achievement of the C.difficile trajectory for no more than 18 cases in 2016/17 with 6 attributable cases and 15 classed as non-trajectory.

Exception to good performance during the year included the following:

- Failure to achieve compliance with the 95% threshold for A&E four-hour waits across Type 1 and Type 3 new attendances. Full year compliance stood at 90.72%;
- Failure to achieve the 2-week cancer targets and 62-day targets consistently during the year;
- Failure to achieve the 99% compliance required on diagnostic tests undertaken within 6 weeks, achieving 98.54%;
- Failure to achieve compliance with the requirement to cancel no more than 1% of operations on the day for non-clinical reasons, achieving 1.16%.

The Trust assures the quality and accuracy of its elective waiting time data through a regular validation process internally, which includes programmed data quality audits and validation by medical secretariat (duty specified in job descriptions). This is overseen by a weekly RTT meeting to ensure the data reported is accurate. Further independent assurances are made through internal audits of data quality.

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Data Security / Information Governance

In 2016/17 the Trust achieved a satisfactory 'green' assessment at 85% for its information governance assurance under the Information Governance Toolkit.This is a maintained score on the previous year. The Trust improved its compliance for staff attending mandatory Information Governance Training achieving 96.88%.

The Trust has had no 'data security' incidents in 2016/17 in relation to loss or interruption of IT Systems caused by external IT security threats. The Trust reported four serious incidents associated with information breaches to the Information Commissioner's Office in line with national guidance. Full investigations were undertaken and action taken.

The Trust was not directly affected by the 'WannaCry' Cyber-attack during May 2017 but took immediate preventive action when alerted to the risk. The Trust considers that it is not possible to eliminate the risk of future attacks but has undertaken further mitigating actions. These include an immediate review of the Capital Investment Programme for IT in 2017/18 to include further security measures around ransomware and third party 'non-Microsoft' patching of vulnerabilities and a programme to undertake the Cyber Essentials self-assessment by explore opportunities for accreditation. Through providing support to Colchester hospital, which was affected by the attack, the Trust has also benefited from being involved in the practice of recovery from such events.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Board receives a monthly report from the Director of Finance, Performance and Strategy on financial performance. Financial performance is reviewed at the Executive and Clinical Management Committees and by the Finance & Performance Committee, which in turn, provides a formal report to the Trust Board in the form of the Integrated Performance Report.

The Trust had an initial planned deficit of £20.1m in 2016/17. The Trust posted a final deficit of £17.6m in 2016/17. The Trust operated in a very challenging environment in 2016/17 with significant increases in non-elective activity over and above the contracted levels and increases to delayed transfers of care (or people medically fit to leave the hospital but with no care package in place). These factors meant the Trust had to open more capacity than planned and had to staff it with locum and agency staff which came at a premium cost. The Trust delivered 97% of its cost improvement programme for the year.

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 in two of the four Divisions, due to risks identified at budget setting not being managed and an unprecedented growth in non-elective activity, although overall the Trust achieved a financial position £2.5m ahead of plan. These issues were spotted early and financial recovery plans were developed to try and address the risks. The Trust believes that all appropriate actions were taken to limit the impact of having to open increased activity.

The Trust regularly benchmarks itself against other Trusts and is regularly in the top 10% Trusts when measured on unit cost basis. During 2016/17, the Trust has worked closely with system partners across the Suffolk and North East Essex footprint with a view to identifying sustainable opportunities across a number of partner organisations. The Trust is currently exploring a long-term partnership with Colchester Hospital University NHS Foundation Trust.

Counter Fraud

The Trust is required under the terms of the Standard NHS Contract and in accordance with the NHS Protect Standards for Providers: Fraud, Bribery and Corruption to ensure appropriate counter fraud measures are in place.

The Local Counter Fraud Group (LCFG) with expertise from the accredited Local Counter Fraud Specialist (LCFS) adopts a risk-based approach to counter fraud

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work, using the NHS Protect Risk Assessment Tool and the incidence of local frauds to identify areas of potential vulnerability. Relevant local proactive exercises are consequently built into the Trust's annual counter fraud work plan, which is overseen by the Audit Committee. The Audit Committee receives assurance on fraud deterrent from regular reports from the Trust's Local Counter Fraud Group and from the Local Counter Fraud Specialist.

The LCFS helps to foster an anti-fraud culture within the Trust through the delivery of training at induction for all staff. This features content on counter fraud and on compliance with the UK Bribery Act 2010.

There was a programme of counter fraud and anti-bribery activity, supported by the LCFG and LCFS whose proportionate annual proactive work plan to address the identified risks, was monitored by the Director of Finance, Performance and Strategy, the deputy Director of Finance and the Audit Committee. Counter Fraud material was disseminated to staff regularly through newsletters, leaflets and posters. Fraud and Bribery Act awareness information was also provided to all staff at induction via the 'Mandatory Training Handbook'. The LCFS held an awareness day at the Trust in October 2016.

The LCFS and LCFG reviewed several policies, including the Counter Fraud joint working protocols and the revised Standards of Business Conduct Policy, to ensure that they were up to date and accurate. Policies are reviewed in line with current legislation and from a best practice and counter fraud perspective.

The LCFS issued 15 Fraud Alerts/Bulletins during 2016/17 relating to subjects such as mandate fraud, increased threats from cyber-attacks, potential telephone fraud, tax refund scams, identity fraud, phishing emails, charitable fraud and IT support fraud which are ongoing fraud issues nationally within the NHS and the wider public sector.

Internal Audit

An annual audit plan is undertaken by Internal Audit and monitored by the Audit Committee. The table on the next page describes the internal audit reviews undertaken in 2016/17 and the level of assurance provided.

The four areas of limited assurances and the reasons for that opinion were as follows:

Departmental Business Continuity Plans

There were some areas of weakness in the divisions' business continuity plans. Whilst contingency arrangements were known to staff, these were not appropriately documented. We will strengthen the documentation in our business continuity plans to address this issue.

Payroll

Continued problems with compliance with payroll procedures has meant that there was a high incidence of overpayments. We have strengthened processes and accountability arrangements and are introducing an electronic solution that is expected will improve compliance.

Cyber Security (Essential Standards)

As the threat of Cyber Security increases so do the standards we hold ourselves to. We requested an internal audit against future standards planned by NHS Digital in order to ensure we had sight of the work we have to do. We continue to be compliant with existing standards and have a comprehensive plan in place to meet the more demanding future standards.

Governance – Community Healthcare contract

The Trust entered into a new contractual joint venture (JV) with West Suffolk Hospital. This has largely been a successful exercise, bringing the delivery of community services back into NHS management, but there were a number of key learning points for how we manage the governance of such arrangements. The audit identified gaps or deviations from the original scope of the planned governance framework for the JV which had not been approved by the Board. Also the quality of financial data reported for the JV was considered poor. The contract that was audited expires in October 2017 and we will ensure the learning is taken into any new arrangements.

The Head of Internal Audit opinion had also placed reliance on the ISAE3402 reports from the auditors of SBS and Serco. Both reports had

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AUDIT	ASSURANCE LEVEL PROVIDED
Financial Systems	Substantial
Information Governance Tool-kit	Substantial
Income – Car Parks	Reasonable
Procurement and Contract Management	Reasonable
A&E Data Quality	Reasonable
VFM – Staff Resource Utilisation	Reasonable
VFM Cost Improvement Plans	Reasonable
VFM Outpatients	Reasonable
Patient Safety – Claims	Reasonable
Workforce – Recruitment and Retention	Reasonable
Estates – Delivering the Strategy	Reasonable
Patient Safety – Safeguarding Adults	Reasonable
BAF and Risk Management	Reasonable
Data Quality – Diagnostic Waits	Reasonable
IM&T – Departments' IT Business Continuity Plans	Limited
IM&T – Cyber Security	Limited
Payroll	Limited
Governance – Community Services	Limited

provided reasonable assurances subject to, for SBS, instances identified where controls in respect of certain objectives were not suitably designed or not operating as designed; and for Serco, control deficiencies identified in relation to IT change controls in respect of control objectives relating to the testing of production environment changes prior to implementation in accordance with documented policies and procedures. These will be followed up by internal audit during their routine audits of relevant areas interfacing with these two organisations during the coming year, with additional application of control measures by the Trust through routine contract management.

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. A report is prepared monthly. The report highlights any recommendations which are past their due date, listed by division. The report indicates new recommendations and those closed during the reporting period.

Review of the Effectiveness of Risk Management and Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the quality report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and reports. I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee, the Workforce, Education and Development Committee and the Finance and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2016/17 stated "I am satisfied that sufficient internal audit work has been undertaken to allow me to draw a reasonable conclusion as to the adequacy and effectiveness of Ipswich Hospital NHS Trust's risk management, control and governance processes. In my opinion, Ipswich Hospital NHS Trust has adequate and effective management, control and

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governance processes to manage the achievement of its objectives".

My review is also informed by executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement is in place.

The Trust Board and its committees meet regularly and, as part of their consideration, keep arrangements for internal control under review through discussion and approval of policies and practice. The Audit Committee has provided the Trust Board with an independent and objective review of financial and corporate governance, and internal financial control within the Trust.

The Audit Committee has received reports from external and internal audit including reports relating to the Trust's counter fraud arrangements. The Trust Executive Directors and managers, and the Chairs of the Quality Committee, Workforce, Development and Education Committee and Finance and Performance Committee of the Board, have provided the Trust Board with reports on risk management, performance management and safety and quality governance.

I have also been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee and Executive Directors. These groups each receive regular reports and updated action plans to manage or monitor progress on major risks, as defined in their respective terms of reference. A plan to address weaknesses and ensure continuous improvement of the system is in place.

A number of external agencies and other assessors' measure and report on the Trust's performance against statutory requirements or best practice. These groups examine many potentially high risk areas. The results of their work are considered and acted on where necessary by the relevant Executive Director. All significant external scrutiny reports are also reported to the appropriate Committee for monitoring in line with the Trust policy on External Agency Visits, Inspections and Visits.

Significant Issues

I have considered the factors described in the NHS Improvement guidance on the 2016/17 annual governance statement in respect of significant issues.

Of the matters identified in this statement, the following is considered to be significant:

Financial sustainability and breakeven duty (in context of pressures from increased non-elective activity and increases in delayed transfers of care

The Trust will continue to focus on delivering realistic levels of savings from sharing internal cost improvements and working with partners in the health system to see if there are benefits from sharing support service functions, having stronger clinical alliances, working better with colleagues in primary care, social services and the community to avoid the continued rise in attendances at hospital and the associated costs to the health and social care system. Plans are being considered relating to our partnership role in delivering the Suffolk and North East Essex STP with the long-term partnership with Colchester Hospital University NHS Foundation Trust representing a significant step forward towards returning to a position of financial sustainability.

The Pathology Partnership

The Pathology Partnership, of which the Trust is a partner, has presented a financial and quality challenge to the Trust during the year, with its investment in the partnership having been impaired by £1.4m. A new model for the

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partnership has been agreed which means that from 05 May 2017, services in the east (West Suffolk, Colchester and Ipswich Hospitals) are to be managed locally as a stand-alone network, with the hub laboratory remaining at Ipswich Hospital and Colchester Hospital University NHS Foundation Trust acting as host.

My review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives. Detailed plans have been reported to the Board and its committees to improve those control issues in these areas and I am satisfied that those issues have been or are being actively addressed.

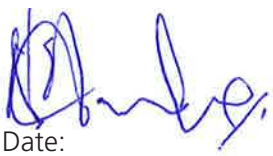
Accountable Officer

The Accountable Officer is Nick Hulme, who is the signatory to the Annual Governance Statement.

Accountable Officer:
Nick Hulme, Chief Executive

Organisation:
The Ipswich Hospital NHS Trust

Signature:



Date:
30 May 2017

Remuneration and Staff Report

Remuneration Policy (Not subject to Audit)

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

The purpose of the Nomination and Remuneration Committee is to identify and appoint candidates to fill all the Executive Director positions and for determining their remuneration and other conditions of service.

In order to meet these objectives, its responsibilities include:

Nomination

- Reviewing the structure, size, composition of the board and leadership needs of the Trust, making recommendations for change as necessary.
- Succession planning for executive board positions.
- Reviewing executive directors' other significant commitments for potential conflicts and/or capacity issues.

Remuneration

- Determining the 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.
- Determining targets for any performance-related pay scheme contained within the policy.
- Reviewing performance and objectives of the Chief Executive and other Executive Directors.
- Ensuring that contractual terms of termination are fair and adhered to.
- Making recommendations to the Board on the level of any additional payments contained within the policy.
- Ensuring that remuneration packages are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

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

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

Executives' pay is reviewed annually. The committee is presented with benchmarking information which compares each Director's salary to similar posts in the NHS. Decisions to uplift salaries are based on this information, internal equity, affordability and whether there has been a significant change in a Director's portfolio during the year. In accordance with Guidance on Pay for Very Senior Managers in NHS Trusts, all proposals for a remuneration package exceeding £142,500 are referred for approval from NHS Improvement, Department of Health, the Minister of State for Health and Her Majesty's Treasury (HMT). 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 2016/17.

Pension Contributions

The Trust made contributions totalling £16.1 million in the year to the NHS Pensions Agency, as per note 6.1 to the accounts. Note 6.3 in the Trust's accounts provide further details as to the nature of the pension scheme and accounting practice in relation to associated liabilities. Details of the pension benefits of the Trust's senior managers are also given in the Remuneration Report.

Expense Payments (excluding benefit in kind expenses)

The Trust has made expense payments to 13 Directors totalling £7,700 during the 2016/17 year and in the 2015/16 year there were payments made to 11 Directors totalling £10,800.

Remuneration and Staff Report

Single Total Figure Remuneration Table

Salary and Pension Entitlements of Board Members (Subject to Audit)

Salary and Pension Entitlements of Board Members 2016/17	Salary (Bands of £5,000) £000	Long-term Performance Pay and Bonuses (Bands of £5,000) £000	Benefits in kind (Rounded to nearest £100) £00	All pension-related benefits (Bands of £2,500) £000	TOTAL (Bands of £5,000) £000
Name and title					
Nick Hulme Chief Executive	80–85	0	4	52.5–55	135–140
Paul Scott Director of Finance and Performance	145–150	0	3	80–82.5	230–235
Barbara Buckley Trust Medical Director (To 30/11/16)	30–35	5–10*	3	235–237.5	275–280
Martin Mansfield Acting Medical Director (19/05/16– 31/03/17)	65–70	5–10*	1	20–22.5	95–100
Lisa Nobes Director of Nursing and Quality	100–105	0	3	242.5–245	345–350
Neill Moloney Managing Director	140–145	0	3	115–117.5	255–260
David White Trust Chair	25–30	0	5	0	25–30
Alan Bateman Non-executive Director (To 06/12/16)	0–5	0	0	0	0–5
Tony Thompson Non-executive Director	5–10	0	1	0	5–10
Andrew George Non-executive Director	5–10	0	2	0	5–10
Laurence Collins Non-executive Director	5–10	0	1	0	5–10
Elaine Noske Associate Non-executive Director (From 16/05/16)	5–10	0	0	0	5–10
Helen Taylor Non-executive Director (From 21/04/16)	5–10	0	1	0	5–10
Richard Kearton Non-executive Director (From 21/04/16)	5–10	0	3	0	5–10

*Clinical Excellence Award.

In May 2016, Nick Hulme and David White were appointed Chief Executive and Chairman of Colchester Hospital University NHS Foundation Trust respectively. The total remuneration received during 2016/17 for both roles across the Ipswich Hospital NHS Trust and Colchester Hospital for Nick Hulme and David White was £205,000 and £58,000 respectively.

In addition, during 2016/17 Barbara Buckley was engaged in a Clinical Advisor capacity at Colchester Hospital University NHS Foundation Trust. The total remuneration received during 2016/17 for both roles across Ipswich Hospital Trust and Colchester Hospital was £132,000.

Remuneration and Staff Report

Single Total Figure Remuneration Table

Salary and Pension Entitlements of Board Members 2015/16	Salary (Bands of £5,000) £000	Long-term Performance Pay and Bonuses (Bands of £5,000) £000	Benefits in kind (Rounded to nearest £100) £00	All pension-related benefits (Bands of £2,500) £000	TOTAL (Bands of £5,000) £000
Name and title					
Nick Hulme Chief Executive	165–170	0	4	35–37.5	200–205
Paul Scott Director of Finance and Performance	135–140	0	2	35–37.5	170–175
Barbara Buckley Trust Medical Director	140–145	35–40*	1	32.5–35	205–210
Lynne Wigens Director of Nursing and Quality (to 30/06/15)	25–30	0	1	17.5–20	40–45
Lisa Nobes Director of Nursing and Quality (from 01/07/15)	75–80	0	2	87.5–90	160–165
Neill Moloney Chief Operating Officer	125–130	0	1	45–47.5	170–175
Ann Tate Trust Chair (to 30/09/15)	10–15	0	2	0	10–15
David White Trust Chair (from 01/11/15)	15–20	0	2	0	15–20
Alan Bateman Non-executive Director (Acting Chair 01/10/15–31/10/15)	5–10	0	0	0	5–10
Tony Thompson Non-executive Director	5–10	0	1	0	5–10
Andrew George Non-executive Director	5–10	0	3	0	5–10
Laurence Collins Non-executive Director	5–10	0	0	0	5–10
Rajan Jethwa Non-executive Director (to 21/01/16)	0–5	0	0	0	0–5

*Clinical Excellence Award.

The 2015/16 Remuneration table has been restated to include only those persons in senior positions having authority or responsibility for directing or controlling major activities within the Trust. This includes those individuals on the Trust Board who influence decisions by way of voting rights.

Remuneration and Staff Report

Pensions Entitlement Table (Subject to Audit)

Pension benefits of Board members

Pension Benefits – Board Members 2016/17 (Subject to audit)

Name	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2017 (Bands of £5,000) £000	Lump sum at retirement age related to accrued pension at pension age at 31 March 2017 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2017 £000	Cash equivalent transfer value at 1 April 2016 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Nick Hulme	0–2.5	5–7.5	50–55	150–155	1,053	954	99	0
Paul Scott	2.5–5	7.5–10	35–40	95–100	540	474	66	0
Neill Moloney	5–7.5	12.5–15	45–50	120–125	680	585	95	0
Barbara Buckley	10–12.5	30–32.5	75–80	230–235	1,634	1,276	239	0
Martin Mansfield	0–2.5	5–7.5	40–45	125–130	836	777	53	0
Lisa Nobes	10–12.5	N/A	50–55	N/A	604	458	146	0

Pension Benefits – Board Members 2015/16

Name	Real increase in pension at retirement age (Bands of £2,500) £000	Real increase in pension lump sum at retirement age (Bands of £2,500) £000	Total accrued pension at retirement age at 31 March 2016 (Bands of £5,000) £000	Lump sum at retirement age related to accrued pension at retirement age at 31 March 2016 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2016 £000	Cash equivalent transfer value at 31 March 2015 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Nick Hulme	0–2.5	2.5–5	45–50	140–145	953	981	38	0
Paul Scott	0–2.5	-2.5–0	30–35	85–90	452	426	14	0
Neill Moloney	0–2.5	-2.5–0	35–40	105–110	564	533	16	0
Barbara Buckley	0–2.5	0–2.5	60–65	185–190	1,275	1,217	25	0
Lynne Wigens	0–2.5	0–2.5	35–40	115–120	762	730	3	0
Lisa Nobes	2.5–5	N/A	35–40	N/A	402	338	41	0

The 2015/16 Pension Benefits table has been restated to include only those persons in senior positions having authority or responsibility for directing or controlling major activities within the Trust. This includes those individuals on the Trust Board who influence decisions by way of voting rights.

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

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

Pension Liabilities

Details of the NHS Pensions Scheme are disclosed in note 6.3 to the accounts.

Directors' Entitlement for Loss of Office (Subject to Audit)

Directors are not entitled to any contractual payment for loss of office. No such payments were made to departing Directors in 2016/17.

Remuneration and Staff Report

Fair Pay (Ratios) Disclosure (Subject to Audit)

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 (Subject to Audit)

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

The remuneration of the highest paid Director in The Ipswich Hospital NHS Trust in the financial year 2016/17 was £147,500 (2015/16, £177,500). This was 5.21 times (2015/16, 6.34) the median remuneration of the workforce, which was £28,292 (2015/16, £27,986). The highest paid Director was the Medical Director in 2015/16 but not in 2016/17 as remuneration costs have been shared with Colchester Hospital University NHS Foundation Trust. The 2015/16 comparatives have been restated in accordance with the Group Accounting Manual, and are based on remuneration rather than salary.

In 2016/17, thirty medical consultant employees (2015/16, four) received remuneration in excess of that of the highest-paid Director. Remuneration ranged from £3,254 to £320,132 (2015/16 £1,585.58 to £283,733).

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

Remuneration and Staff Report

Staff Report

Staff Costs (Subject to Audit)	2016/17			
	£000s Total	£000s Permanently employed	£000s Agency/Contract	£000s Other
Salaries and wages	**148,593**	**131,329**	**10,952**	**6,312**
Social Security Costs	**12,793**	**12,136**	**-**	**657**
NHS Pension Scheme	**16,051**	**15,417**	**-**	**634**
Other Pension Costs	**-**	**-**	**-**	**-**
	177,437	**158,882**	**10,952**	**7,603**
Costs Capitalised as part of Assets	**481**	**362**	**74**	**45**
Total Employee Benefits (excluding Capitalised Costs)	**176,956**	**159,244**	**11,026**	**7,648**

Staff Costs (Subject to Audit)	2015/16			
	£000s Total	£000s Permanently employed	£000s Agency/Contract	£000s Other
Salaries and wages	140,645	124,594	11,886	4,165
Social Security Costs	9,615	9,026	-	589
NHS Pension Scheme	15,111	14,542	-	569
Other Pension Costs	13	13	-	-
	165,384	148,175	11,886	5,323
Costs Capitalised as part of Assets	865	357	465	43
Total Employee Benefits (excluding Capitalised Costs)	**164,519**	**148,532**	**12,351**	**5,366**

Remuneration and Staff Report

Staff Report

Staff Numbers by WTE (Subject to Audit)

	2016/17			2015/16 Restated*
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Ambulance staff	**2**	2	0	0
Administration and estates staff	**923**	882	41	832
Healthcare assistants and other support staff	**786**	668	118	755
Medical and dental staff	**494**	465	29	467
Nursing, midwifery and health visiting staff	**1,291**	1,126	165	1,218
Nursing, midwifery and health visiting learners	**6**	6	0	5
Scientific, therapeutic and technical staff	**411**	391	20	397
Healthcare Scientists	**69**	64	5	60
Total	**3,982**	**3,604**	**378**	3,734

*Numbers of agency staff have been incorporated in the above figures.

Staff Gender Breakdown

	2016/17		2015/16	
	Number		Number	
	Female	**Male**	Female	Male
Contracted staff	**3,480**	**890**	3,335	861
The Trust maintains a bank of staff who can be called on as required	**2,425**	**418**	2,319	438
Total	**5,905**	**1,308**	5,654	1,299

Board Gender and Payscale Breakdown

	2016/17		2015/16	
	Number		Number	
	Female	**Male**	Female	Male
Non-executive Director	2	6	1	6
Very Senior Manager (VSM)	4	4	6	3
Total	**6**	**10**	**7**	**9**

Remuneration and Staff Report

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The Trust continues to work towards the achievement of the NHS pledges as outlined in the NHS Constitution to ensure that all staff feel trusted, actively listened to, provided with meaningful feedback, treated with respect at work, have the tools, training and support to deliver compassionate care, and are provided with opportunities to develop and progress.

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

- a place to work;
- a place to receive treatment;
- a place to be trained.

National NHS Staff Survey

The 13th national NHS staff survey took place in Quarter 3 with a random selection of staff from all Trusts required to participate. Of the 1,216 staff invited to take part, 559 responded. The response rate of 46% was above average for acute trusts in England and comparable to the 49% response rate in the 2015 survey.

Key Findings

Our staff engagement and motivation score showed a slight decrease from 3.85% to 3.81% (1 being poorly engaged staff to 5 being highly engaged staff). This is an average score when compared with other acute trusts. However, we continue to encourage further engagement and to increase staff ability to contribute towards improvements at work.

Staff recommendation of the organisation as a place to work or receive treatment remains above average.

There are no statistically significant changes in the scores from last year. However, after last year when the Trust improved in 24 areas, it was disappointing to have five improved scores, four remaining the same and some slight decreases. This has affected our performance against the average comparator for all acute trusts where we now have 21 comparators below average, five equal to the average and six above as opposed to the 28 equal to and above in 2015.

The Trust has three scores in the top 20%:

- believing the Trust provides equal opportunities for career progression
- feeling unwell due to work related stress in last 12 months
- experiencing physical violence from staff in last 12 months

These, along with the next two scores, form the five top ranking scores where Trust percentages compare most favourably with other acute trusts:

- staff/colleagues reporting most recent experience of violence
- reporting errors, near misses or incidents witnessed in the last month.

Areas to address

After a challenging year for the Trust, although some impact on staff could be anticipated, the lower scores were disappointing against 2015 with 11 in the bottom 20%, against two in this category in 2015.

A new appraisal process *Improving Together* was launched in April 2016 and was halfway through its first year when the staff survey was undertaken. Feedback about the new process has been positive but still needs to be fully implemented and embedded before outcomes can be evaluated.

In December 2016, we appointed a Freedom to Speak Up Guardian

Remuneration and Staff Report

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to ensure there was a dedicated 'go to' person when staff need to speak up and other avenues are not suitable. We will also be looking at all ways in which to improve this score (see our Quality Account).

Taking care of health and wellbeing is a key priority in the challenges we face going forward. Appointing a specialist partner in 2016 to provide an Employee Assistance Programme for support and advice was a key driver for this agenda. In addition, we are working with Suffolk Mind to implement a plan to train and support staff on emotional need, effective communication and stress management. This is a programme of personal development to support and improve emotional wellbeing amongst all grades of staff.

Recruitment of staff

Recruitment drive initiatives have also been undertaken to address difficult to fill posts and to reduce the number of times that staff are required to work extra hours. We have held three international nurse recruitment campaigns and taken a number of actions to address our 'difficult to recruit to' posts.

As part of the workforce strategy review and non-mandatory training provisions, we will be looking at training, information, and communication needs and other ways of addressing this.

The Trust's vision and values were developed by staff, patients and key stakeholders and apply to all with crucial linkage between good patient and workforce experiences. We plan to have a stronger focus on having conversations with staff on what matters to them.

Listening to and engaging with our staff

The findings from the staff survey will help inform targeted, robust actions for continuous improvement as essential steps to restore our workforce position and ensure the Trust is a good place to work and train. The Trust's corporate strategy for 2017–2022 *Writing the next chapter* has recently launched, and patient experience and workforce strategies are being prepared which will underpin the actions we are taking to address the findings from our staff survey. We will ensure this is a key priority including fully addressing the linkage between staff experience and patient experience.

Good communication between senior managers and staff has been a common theme raised by staff in recent years and this will be one of areas for focus during 2017/18.

Sharing our story...

Memories thanks to vintage shop fronts

Older patients are being given help to reminisce thanks to an old-fashioned mock shop front.

The 'shop' includes old-style packages for family favourites, such as teabags, tapioca, cocoa and broken biscuits, all from days gone by. The items have been donated by the Co-Op, and are used to trigger memories and conversations in older patients with dementia, in turn helping them to feel safer and more comfortable during their hospital stay.

A mock shop opened on the Constable Suite – the hospital's complex care unit – a few years ago. It proved so successful that a second has been added in a day room shared by the Woodbridge and Washbrook wards.

Remuneration and Staff Report

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Workforce Race Equality Standard (WRES)

The NHS WRES was introduced in 2015 to help enable Black Minority Ethnicities (BME) to have equal access to career opportunities and fair treatment in the workplace after research indicated potentially less favourable treatment of these groups in the NHS.

The Trust measures progress against nine indicators of workforce race equality which focus on any differences between the experience and treatment of White and BME staff. This also marks the level of BME representation at senior management and board level and helps to plan evidence-based action. A national database will be benchmarking national and local progress.

There is a substantial improvement for the Trust in metric KF26 for BME staff experiencing poor conduct from other staff which has decreased from 43% to 26% in 2016.

The full and summary survey reports for Ipswich Hospital are available at www.nhsstaffsurveys.com

Equality and Diversity

Equality is about fair and inclusive treatment. It is protected in law with the aim that we can all live and work in a society where everyone can participate, have opportunity to fulfil potential and fair access to services and employment.

Diversity supports equality, recognising and understanding the broad range of differences which makes someone unique such as their culture, belief, gender, age, physical or mental abilities, and also their experiences, needs, expectations or responsibilities.

Being fair and inclusive means valuing and respecting a person's diverse requirements, thoughts and contribution. Equality and diversity work in unison to achieve all this.

Why this agenda is important

The people we serve and employ are becoming increasingly diverse with varied needs, but everyone needs to feel valued and included and treated fairly and respectfully. The Trust, our patients, staff and stakeholders have all identified and made a commitment to this within our shared values and our expectations of conduct. Everyone is responsible for supporting this agenda.

Our responsibilities and ensuring delivery

Equality, firmly underpinned in the Equality Act 2010, ensures people do not receive unfair treatment or be subjected to discrimination or harassment due to their age, race, gender, belief, sexual orientation, transgender, in marriage or civil partnership or in pregnancy or maternity. To ensure we meet these responsibilities, the Workforce, Development and Education Committee overviews this agenda for the workforce, whilst the Quality Committee reviews service provision.

NHS Equality Delivery System

Like all NHS organisations, the Trust uses the Equality Delivery System (EDS2) to implement equality and diversity strategies and the Public Sector Equality Duty. There are four overarching goals:

- better health outcomes;
- improved patient access and experience;
- a representative and supported workforce;
- inclusive Leadership.

More details can be found at: www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Engagement and involvement with patients, staff and stakeholders

A key part of EDS2 is the identification of stakeholders from patients, staff, or local interest groups to secure meaningful engagement to help assess and evaluate where we are and how to progress. This partnership approach to engagement and involvement with communities helps us focus on what matters most for our patients, communities and staff.

Embedding equality and diversity

EDS2 helps identify, develop and implement objectives to continue to make real, sustainable

Remuneration and Staff Report

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improvement to our services and working conditions whilst delivering better outcomes and benefits to meet the needs of staff and service users.

The equality objectives and priorities are also aligned to the Trust's organisational priorities to ensure relevance and to realise full benefits within the Trust's corporate, workforce and patient strategies. This helps embed the agenda into our governance structure and into all activities for effective implementation.

NHS Accessible Information Standard (AIS)

Application of the AIS helps to meet needs in relation to a disability, impairment or sensory loss which affects the ability to communicate.

The AIS applies to patients, carers or parents. We try to address any information/communication support needs to enable better access to services and care to give a better patient experience.

Commitment to promoting equality and diversity in the workforce, and inclusive leadership is crucially associated with increased patient-centred innovation, care, staff morale and access to a wider talent pool.

Workforce Race Equality Standard (WRES)

EDS2 covers all areas of diversity across services and the workforce. The WRES focuses on workforce and race as a particular NHS need to improve performance in this area where there is potentially less favourable treatment and experience of BME staff in the NHS.

Workforce Disability Equality Standard (WDES)

The WDES is a new development to improve performance. We will also be looking to improve services for those with a disability.

Care Quality Commission (CQC)/equality diversity and human rights agenda

Equality and diversity is inspected by the CQC as part of the 'well led' domain of the NHS inspection programme. This includes analysis of EDS2 and WRES reports, action plans and how issues arising from equality data are addressed.

Our commitment continues

The Trust aims to achieve a diverse workforce reflective of and sensitive to the needs of the community. We will work towards eliminating discrimination, promoting equal opportunity and removing barriers to fair and equal treatment of staff and patients. Support from the Trust Board ensures full ownership and accountability for this agenda. The Board is involved in and approves equality developments and understands their role, and legal requirements.

Sharing our story...

Extra help for stroke recovery

Patients recovering from a stroke are now receiving even more specialist help to rehabilitate following the introduction of a new exercise group at our hospital.

The upper limb physiotherapy group has been set up to help patients on Shotley Ward to improve their practical skills and regain movement in their arms and hands following a stroke.

It sees colleagues from the stroke therapy team offer tailored support to groups of patients using techniques to improve their dexterity and help retrain their brain.

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Staff Sickness

(Not Subject to Audit)

The Trust's rolling 12-month sickness rate is at 4.03% (12 months to 31 March 2017). This compares to 3.82% in March 2016.

The most recent published data for the acute medium trusts (November 2015) lists the sickness rate as 3.88% which is higher than that recorded for The Ipswich Hospital NHS Trust at 3.64%.

Freedom to Speak Up Guardian

Our first Freedom to Speak Up Guardian, Tom Fleetwood, took up his post on 1 December 2016. Tom is working across both Ipswich and Colchester hospitals for three days each week.

Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.

Tom grew up around the Colchester area and was a non-executive director of Colchester Hospitals University NHS Foundation Trust until taking up the Guardian role. He had a long career in the Army, the last three years of which were spent as the Commander of Colchester Garrison.

Tom said: "I am very honoured to be appointed to this role and to be given the opportunity to support all staff, at every level. This will be a challenging job, but with considerable opportunity and I am looking forward to it."

The Freedom to Speak Up Guardian role was developed as a recommendation of the Francis Review, looking at failings in care at Mid-Staffordshire Trust to make sure that hospitals have a dedicated 'go to' person for when staff need to speak up and other avenues are not suitable.

Acting in a genuinely independent capacity, Tom will work alongside both boards of directors and executive teams to continue developing both organisations as open and transparent places to work.

Guardian of Safe Working Hours (GSWH)

The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors and dentists are not working unsafe hours.

The Guardian of Safe Working Hours is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service for doctors and dentists in training. It is a role intended to be undertaken by a consultant or

Sharing our story...

New cancer centre opens

Our £4.7m Woolverstone Macmillan cancer centre opened its doors to its first patients in May 2016.

The centre brings together all outpatient chemotherapy, oncology and haematology day services in a modernised environment. It features a spacious waiting room, consulting rooms to give patients and loved ones privacy and dignity and 30 treatment chairs (including private bays) set in a bright, airy space with plenty of room for visitors.

Remuneration and Staff Report

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someone of equivalent seniority. The Guardian reports directly to the Trust Board and is independent of the management structure within the organisation.

Dr Mark Garfield, a consultant anaesthetist, has been appointed to this role for the Trust.

To fulfil this role, the Guardian will:

- act as the champion of safe working hours;
- receive exception reports and record and monitor compliance against terms and conditions;
- escalate issues to the relevant executive director, or equivalent for decision and action;
- intervene to reduce any identified risks to doctors/dentists or to patient safety;
- undertake a work schedule review where there are regular or persistent breaches in safe working hours; and
- distribute monies received as a consequence of financial penalties, to improve training and service experience.

The Guardian attended the launch meeting in July 2016, and is a member of the regional network, the first meeting of which was held in mid-February 2017. He also attended the second national Guardian event in March 2017. The networks will support the development of the GSWH role and the sharing of best practice.

The 2016 contract went live on 3 August 2016. Within the Trust the FY1 doctors in general surgery, trauma & orthopaedics, anaesthetics and psychiatry transitioned on 7 December 2016. This comprises a total of 16 doctors. On 6 March 2017, seven paediatric registrars transitioned onto the new contract.

The Trust uses an electronic exception reporting system (Allocate) which enables doctors to submit exception reports from any IT device. The system also supports the management of exception reports and work schedule reviews so the Guardian can monitor progress with resolving issues. A doctor can submit an exception report if their working pattern varies from the work schedule or they have missed educational opportunities.

To date, no exception reports have been submitted.

Engagement

Engagement with the Educational Supervisors (ES) has been challenging as there appears to be a lack of appreciation as to the implications of the new contract and exception reporting, and also some resistance in view of the recent reduction in PA allocation for ES. Postgraduate staff and the Guardian ES have contacted ES throughout November and December with training materials and links for webinars, and the Guardian also attended the Medical Staff Committee meeting in February.

Junior Doctors Forum

The Guardian and the Director of Medical Education have established the Junior Doctor Forum which is a requirement of the 2016 contract. The inaugural meeting was held in mid-January. There was limited attendance from junior doctor representatives, however, this is comparable to the experience of other trusts. Methods to improve junior doctor engagement has been discussed with the LNC.

Terms of reference and membership have been approved and the Forum will meet quarterly. The junior doctors elect their Forum representatives and they have been encouraged to widen their membership to include a more diverse representation across the Trust.

Rota gaps

There are a number of gaps in rotas across the Trust due in part to vacancies. These are being proactively managed and covered in a number of different ways, including the appointment of Trust doctors, use of temporary staff (bank and locums) and the reassignment of some medical roles to nurse specialists, in order to limit the impact on patients.

Remuneration and Staff Report

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Our key achievements

- Appointment of Dr Mark Garfield as Guardian of Safe Working Hours;
- Task and finish group initiated to ensure compliance with national timescales for implementation of new junior doctors' contract;
- Establishment of a Junior Doctors' Forum to assist the GSWH in carrying out his role;
- Transition of junior doctors to the new contract according to the national timeline, with phased implementation until October 2017;
- Quarterly Board reports submitted in January 2017 and April 2017, for Q3 and Q4;
- Guardian attendance at the Local Negotiating Committee (LNC) meeting to report on and discuss issues.
- Training events held on the exception reporting and work schedule review process with junior doctors, and presentation about the role to the Medical Staff Committee;
- Support and online training provided to educational supervisors regarding their role regarding work schedules and exception reporting;
- Development of the Exception Reporting and Work Schedule Review Policy;
- Review of junior doctor rotas to ensure compliance with the 2016 contract requirements;
- Appointment of a champion of flexible training to provide support and advice to less than full-time trainees;
- Completion of the Equality Impact Assessment for the implementation of the new contract in accordance with the Public Sector Equality Duty obligations.

Sharing our story...

Kissing it Better

We are working with the charity Kissing it Better to improve our patients' experiences. Local schools, colleges and community groups are bringing hand massages, singing, music, poetry and hairdressing to the wards.

Remuneration and Staff Report

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Off-payroll Engagements (Not Subject to Audit)

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	30
Of which, the number that have existed:	
for less than 1 year at the time of reporting	15
for between 1 and 2 years at the time of reporting	8
for between 2 and 3 years at the time of reporting	5
for between 3 and 4 years at the time of reporting	2
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 conducts checks and seeks assurances regarding employment status.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	16
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	16
Number for whom assurance has been requested	6
Of which:	
assurance has been received	5
assurance has not been received	1
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	16

Consultancy

The Trust paid £185k for consultantancy services during 2016/17.

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:

Date:
30 May 2017

Remuneration and Staff Report

Staff Report

Staff Sickness Absence and Ill-health Retirements (Not Subject to Audit)

	2016/17	2015/16
	Number	Number
Total hours lost	**282,393**	252,399
Total staff years	**3,612**	3,372
Average working hours lost	**78.18**	74.85
Persons retired early on ill-health grounds	**4**	1

Exit Packages and Severance Payments (Subject to Audit)

There were no exit packages agreed in 2015/16.

	2016/17			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Total number of exit packages	Total cost of exit packages
Staff Banding	Number	£s	Number	£s
Less than £10,000	**1**	**4,660**	**1**	**4,660**
£25,001 – £50,000	**1**	**42,061**	**1**	**42,061**
Total	**2**	**46,721**	**2**	**46,721**

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change terms and conditions of service. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

Exit Packages – Other Departures Analysis (Subject to Audit)

There were no exit packages for other departures in 2016/17 (2015/16 None).

There were no non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary (2015/16 None).

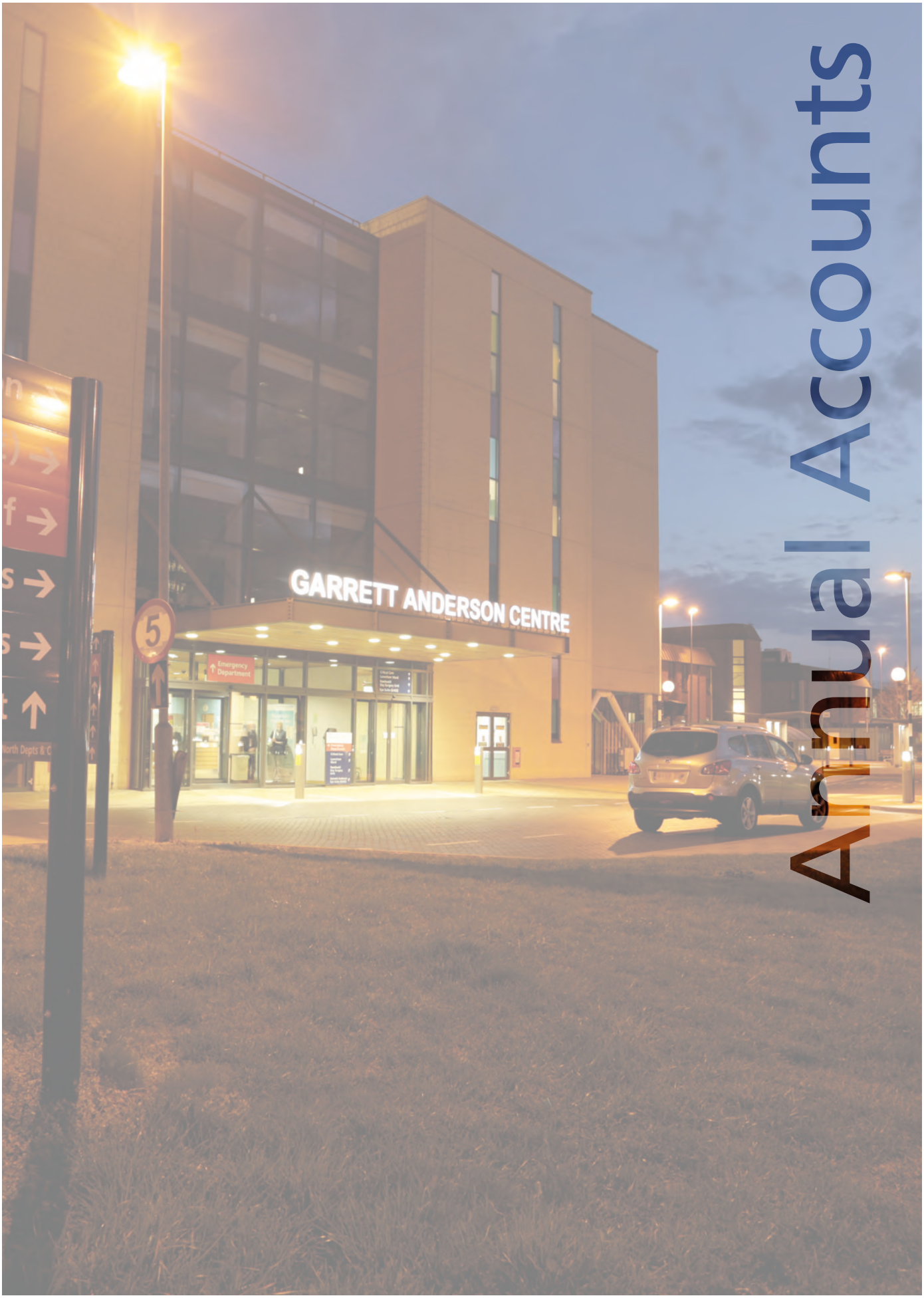
This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

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

Glossary

Glossary of Terms	
A&E	• Accident and Emergency (Casualty)
Carter Review	• Review of Operational Productivity in NHS providers by Lord Carter of Coles
CCG	• Clinical Commissioning Group
CHP	• Combined Heat and Power
DH	• Department of Health
DNACPR	• Do Not Attempt Cardio Pulmonary Resuscitation
DToC	• Delayed transfer of care
ED	• Emergency Department
GAC	• Garrett Anderson Centre
GCC	• Good Corporate Citizen
IHT, the hospital, the Trust, we	• The Ipswich Hospital NHS Trust
ISS	• Provider of facilities services to the Trust
NHS	• National Health Service
PHSO	• Parliamentary and Health Service Ombudsman
PLACE score	• A patient-led assessment of the hospital environment
Red to Green	• An Ipswich Hospital initiative to give patients back their lives
RTT	• Referral to treatment
SDMP	• Sustainable Development Management Plan
STP	• Sustainability Transformation Plan
WMC	• Woolverstone Macmillan Centre
WTE	• Whole time equivalent



Annual Accounts

Ipswich Hospital NHS Trust

Annual Accounts for the period

1 April 2016 to 31 March 2017

FOREWORD TO THE ACCOUNTS
THE IPSWICH HOSPITAL NHS TRUST

These accounts for the year ended 31 March 2017 have been prepared by The Ipswich Hospital NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE IPSWICH HOSPITAL NHS TRUST

We have audited the financial statements of The Ipswich Hospital NHS Trust (the Trust) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 (the 2016-17 GAM) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is described in that report as having been audited.

This report is made solely to the Board of Directors of The Ipswich Hospital NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the Statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of The Ipswich Hospital NHS Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Emphasis of matter - going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosures made in Note 1.19 in the financial statements concerning the financial position of the Trust in the context of the National Health Service framework in which it operates. As explained in note 1.19 this matter indicates the existence of a material uncertainty related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

Exception report - section 30 referral

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 31 May 2017 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 as the Trust has breached its statutory breakeven duty.

Exception report - use of resources

Auditor's responsibilities

We report to you if we are not satisfied that the trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The Trust's outturn position for 2016/17 was a £22.3 million adjusted retained deficit in line with its control total, achieved in part through non-recurrent means which places additional strain on the Trust in the forthcoming financial year. The 2017/18 forecast deficit is £25.2m (after receipt of Sustainability and Transformation Funding of £7.2 million) with a Cost Improvement Programme (CIP) savings target of £15.8m that will need to be achieved to realise this outcome. £9.3m (59%) of the £15.8m CIP target is currently unidentified. This presents a significant challenge to the Trust.

NHS Improvement's Single Oversight Framework rates Trusts in a number of areas including finance and use of resources, scoring providers 1 (best) to 4 against each metric. The Trust's Financial Reporting risk rating is 3 and is expected to remain at this level for 2017/18 and 2018/19. The Trust's medium term financial plan does not return the Trust to a breakeven position without additional funds being made available.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, The Ipswich Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Other matters we report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Trust Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of The Ipswich Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

BDO LLP

Lisa Clampin

For and on behalf of BDO LLP, Appointed Auditor
Ipswich, UK

01 June 2017

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

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	6.1	**(176,956)**	(164,519)
Other operating costs	5	**(137,569)**	(119,160)
Revenue from patient care activities	3	**259,477**	241,108
Other operating revenue	4.1	**36,974**	25,202
Operating deficit		**(18,074)**	(17,369)
Investment revenue		**18**	26
Finance costs		**(2,549)**	(2,247)
Deficit for the financial year		**(20,605)**	(19,590)
Public dividend capital dividends payable		**(1,735)**	(2,673)
Retained deficit for the year		**(22,340)**	(22,263)

Other Comprehensive Income	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**1,376**	(1,423)
Total comprehensive income for the year	**(20,964)**	(23,686)

Financial performance for the year		
Retained deficit for the year	**(22,340)**	(22,263)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**(256)**	175
Impairments (excluding IFRIC 12 impairments)	**7,557**	2,744
Adjustments in respect of donated/gov't grant asset reserve elimination	**(2,539)**	(2,754)
Adjusted retained deficit	**(17,578)**	(22,098)

NHS Trusts have a statutory requirement to break even year on year. The Department of Health has determined that certain items should be excluded from the breakeven calculation. Further details are given in note 22.1

* IFRIC 12 is the interpretation of International Financial Reporting Standard 12, which deals with extra statutory concessions. The Trust's Private Finance Initiative (PFI) scheme is covered by this standard, as detailed in note 1.10.

The notes on pages 12 to 40 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	8	**133,896**	132,204
Intangible assets	9	**5,094**	5,373
Other financial assets		**-**	1,282
Trade and other receivables	11.1	**1,410**	821
Total non-current assets		**140,400**	139,680
Current assets:			
Inventories		**5,042**	4,464
Trade and other receivables	11.1	**27,966**	16,295
Cash and cash equivalents	12	**943**	879
Total current assets		**33,951**	21,638
Total assets		**174,351**	161,318
Current liabilities			
Trade and other payables	13	**(40,396)**	(36,031)
Provisions	16	**(568)**	(358)
Borrowings	14	**(1,471)**	(1,312)
Total current liabilities		**(42,435)**	(37,701)
Net current assets/(liabilities)		**(8,484)**	(16,063)
Total assets less current liablilities		**131,916**	123,617
Non-current liabilities			
Provisions	16	**(1,037)**	(1,053)
Borrowings	14	**(25,064)**	(26,287)
DH revenue support loan	14	**(48,802)**	(19,050)
Total non-current liabilities		**(74,903)**	(46,390)
Total assets employed:		**57,013**	77,227
FINANCED BY:			
Public Dividend Capital		**93,502**	92,752
Retained earnings		**(62,799)**	(41,693)
Revaluation reserve		**26,310**	26,168
Total Taxpayers' Equity:		**57,013**	77,227

The notes on pages 12 to 40 form part of this account.

The financial statements on pages 8 to 40 were approved by the Board on 25 May 2017 and signed on its behalf by

Chief Executive:  Date: 30/5/17

Statement of Changes in Taxpayers' Equity fo the Year Ended 31 March 2017

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2016	**92,752**	**(41,693)**	**26,168**	**77,227**
Changes in taxpayers' equity for 2016-17				
Retained deficit for the year	-	(22,340)	-	**(22,340)**
Impairments and reversals	-	-	1,376	**1,376**
Transfers between reserves	-	1,234	(1,234)	-
Reclassification Adjustments				
Temporary and permanent PDC received - cash	750	-	-	**750**
Net recognised revenue/(expense) for the year	**750**	**(21,106)**	**142**	**(20,214)**
Balance at 31 March 2017	**93,502**	**(62,799)**	**26,310**	**57,013**
Balance at 1 April 2015	**93,469**	**(20,763)**	**28,924**	**101,630**
Changes in taxpayers' equity for the year ended 31 March 2016				
Retained deficit for the year	-	(22,263)	-	(22,263)
Impairments and reversals	-	-	(1,423)	(1,423)
Transfers between reserves	-	1,333	(1,333)	-
Reclassification Adjustments				
New PDC received - cash	33	-	-	33
PDC repaid in year	(750)	-	-	(750)
Net recognised expense for the year	**(717)**	**(20,930)**	**(2,756)**	**(24,403)**
Balance at 31 March 2016	**92,752**	**(41,693)**	**26,168**	**77,227**

Statement of Cashflows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating deficit		**(18,074)**	(17,369)
Depreciation and amortisation	8	**9,641**	9,536
Impairments and reversals	10	**7,301**	2,919
Increase in Inventories		**(578)**	(213)
(Increase)/Decrease in Trade and Other Receivables		**(12,342)**	6,484
Increase in Trade and Other Payables		**6,216**	3,958
Provisions utilised		**(308)**	(333)
Increase in movement in non cash provisions		**487**	248
Net Cash Inflow/(Outflow) from Operating Activities		**(7,657)**	5,230
Cash Flows from Investing Activities			
Interest Received		**18**	26
Payments for Property, Plant and Equipment		**(11,686)**	(12,626)
Payments for Intangible Assets		**(890)**	(592)
Payments for Other Financial Assets		**(4,554)**	(2,682)
Proceeds of disposal of assets held for sale (PPE)		**662**	-
Net Cash Outflow from Investing Activities		**(16,450)**	(15,874)
Net Cash Outflow before Financing		**(24,107)**	(10,644)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**750**	33
Gross Temporary and Permanent PDC Repaid		**-**	(750)
Loans received from DH - New Revenue Support Loans		**51,630**	36,374
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(21,878)**	(17,324)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(2,143)**	(2,072)
Interest paid		**(2,535)**	(2,245)
PDC Dividend paid		**(1,653)**	(2,646)
Net Cash Inflow from Financing Activities		**24,171**	11,370
NET INCREASE IN CASH AND CASH EQUIVALENTS		**64**	726
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**879**	153
Cash and Cash Equivalents (and Bank Overdraft) at year end	**12**	**943**	879

NOTES TO THE ACCOUNTS

1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

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

1.2 Critical Judgements and Key Sources of Estimation Uncertainty

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.2.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

PFI

Payments in respect of the Trust's PFI agreement are apportioned between ongoing maintenance, interest charges and repayment of the capital sum outstanding in accordance with an agreed formula which is designed to yield a representative split of costs into the respective categories, and to eliminate the PFI creditor by the end of the agreement.

Non-Consolidation of Charitable Funds

IFRS10 requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS10 defines a subsidiary as "an entity...that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities." The Trust is Corporate Trustee of the Charitable Fund and meets the definition of control.

Materiality is an overriding consideration in preparation of the accounts. The International Accounting Standards Board (IASB) states that "Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements".

The net assets of the Charitable Fund amount to about 3% of the Trust net assets. Charitable fund income is about 0.4% of Trust income. The Directors therefore consider that the significant amount of work which would be necessary to consolidate the accounts of the Charitable fund with those of the Trust is not justified on the grounds of materiality.

Investment in Pathology Service

The Trust is a Partner in the Pathology Partnership, a regional pathology service hosted by Cambridge University Hospitals NHS Foundation Trust. The investment is shown at the lower of cost and estimated fair value.

Pensions

Critical judgements have been applied in accounting for pensions. These are detailed in note 6.

Intangible Assets

The intangible assets balance is composed entirely of software licences. These are stated at historic amortised cost on the basis that this is not materially different from their fair value.

NOTES TO THE ACCOUNTS

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

1.2.2 Key Sources of Estimation Uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions and contingencies
In considering the amounts to be accounted for under provisions and contingent liabilities the Trust makes a judgement on the likelihood of liabilities arising in respect of pensions, public and employers liability and injury benefit. These are based on measures such as discounted actuarial values of pensions and calculations of approximate liabilities under carbon reduction schemes.

Depreciation, Amortisation and useful economic lives
The Trust's basis for determining these estimates is explained in note 1.8.

Impairment of Pathology Service
The Trust has provided an impairment based on estimated future cash flows. Impairments may be classified as Annually Managed Expenditure (AME) or Departmental Expenditure Limit (DEL). The Trust considers that, on balance, the impairment is more appropriately classified as AME.

Revaluation of Property, Plant and Equipment
The Trust engaged valuers (Gerald Eve LLP) to review the Trusts Estate and provide updated valuations as at 31 March 2017. As part of this process, the Trust requested a valuation of the Trusts main hospital (land) on an alternative site basis.

It is the Trusts judgement that the current site is not essential to the provision of healthcare locally and that an alternative site has therefore be considered when determining the valuation; on the basis that it is at least as beneficial in serving the local population, both in terms of location and accesibility. The location identified which in the Trusts view satisfies this criteria, is the British Sugar site on Sproughton Road, approximately 4 miles from the main hospital, with close access to the A14. The Trusts main hospital land has therefore been valued this basis.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. Final agreement of income is reached after closure of the accounts. The figures included in the accounts are reflective of activity performed.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.4 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

NOTES TO THE ACCOUNTS

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

1.5 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.6 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value in existing use at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Valuations are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Land and buildings that are surplus to requirements are valued at fair value using IFRS 13, unless there are restrictions on the entity or the asset which would prevent access to the market and are valued at current value in existing use as above.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

NOTES TO THE ACCOUNTS

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

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operating of hardware, for

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when

Following initial recognition, intangible assets are carried at amortised cost. Internally-developed software is held at amortised cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Government Grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

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

1.10 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received:
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured in accordance with the accounting policy for property, plant and equipment, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

NOTES TO THE ACCOUNTS

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

1.11 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

1.12 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 16.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

1.14 Financial Assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Trust financial assets are classified as Loans and Receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

The amount of any impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.15 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

NOTES TO THE ACCOUNTS

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

1.16 Value Added Tax

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

1.17 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets, adjusted for in-year changes in capital and daily cleared balances with the Government Banking Service.

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

1.18 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.19 Going Concern

The Trust has reported a retained deficit of £22.3m for 2016/17 (2015/16 deficit: £22.3m), with net assets employed as at 31 March 2017 of £57m (2015/16: £77.2m). The Trust is not expected to return to a surplus during the current planning period 2017/18 – 2018/19.

Although this represents a material uncertainty which may cast significant doubt related to financial sustainability (profitability and liquidity) in terms of the Trust continuing to operate as a going concern, the Trust has the backing of the Secretary of State for Health evidenced by the funding of deficits in the form of loans issued by the Department of Health.

The Trust has planned income in 2017/18 of £293.5m, the substantial portion of which is backed by contract, all of which had been signed as at 31 March 2017.

In consideration of the above; as directed by the 2016/17 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services provided by the Trust will be provided in the foreseeable future.

NOTES TO THE ACCOUNTS

2 Operating Segments

The Chief Operating Decision Maker of Ipswich Hospital NHS Trust is the Trust Board, with reporting to the Trust Board and decision making, based on the Trust as a whole.

The Ipswich Hospital NHS Trust has one operating segment which is the provision of healthcare services. The revenue from patient and non patient care activities is detailed below in Notes 3 and 4.

3 Revenue from Patient Care Activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**92**	176
NHS England	**47,878**	41,733
Clinical Commissioning Groups	**197,003**	188,438
Foundation Trusts	**10,350**	6,529
NHS Other (including Public Health England and Prop Co)	**85**	141
Additional income for delivery of healthcare services	**-**	750
Non-NHS:		
Local Authorities	**1,365**	814
Private patients	**687**	605
Overseas patients (non-reciprocal)	**203**	142
Injury costs recovery	**910**	753
Other Non-NHS patient care income	**904**	1,027
Total Revenue from Patient Care Activities	**259,477**	241,108

4.1 Other Operating Revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**3,017**	2,279
Education, training and research	**10,094**	10,129
Charitable and other contributions to revenue expenditure -non- NHS	**-**	12
Receipt of charitable donations for capital acquisitions	**2,934**	2,968
Non-patient care services to other bodies	**1,404**	1,651
Sustainability & Transformation Fund Income	**7,847**	-
Income generation (Other fees and charges)	**3,630**	3,770
Rental revenue from operating leases	**205**	185
Other revenue (see below)	**7,843**	4,208
Total Other Operating Revenue	**36,974**	25,202
Total Operating Revenue	**296,451**	266,310

Other Revenue includes the following,

	£000
Continence Products Revenue	**2,347**
Pathology Services	**2,121**
System Capacity Support - Non Recurrent Funding	**2,000**
E-Prescribing Project Funding	**497**

NOTES TO THE ACCOUNTS

4.2 Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**203**	142
Cash payments received in-year (re receivables at 31 March 2016)	**30**	25
Cash payments received in-year (iro invoices issued 2016-17)	**44**	47
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**11**	6
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**53**	9
Amounts written off in-year (irrespective of year of recognition)	**35**	8

5 Operating Expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**165**	285
Services from CCGs/NHS England	**115**	37
Services from other NHS bodies	**67**	47
Services from NHS Foundation Trusts	**1,353**	1,105
Total Services from NHS bodies*	**1,700**	1,474
Purchase of healthcare from non-NHS bodies	**8,233**	8,734
Trust Chair and Non-executive Directors	**68**	60
Supplies and services - clinical	**62,897**	56,587
Supplies and services - general	**15,351**	10,927
Consultancy services	**185**	86
Establishment	**9,512**	8,196
Transport	**307**	258
Service charges - ON-SOFP PFIs and other service concession arrangements	**807**	799
Business rates paid to local authorities	**1,171**	1,112
Premises	**4,855**	4,677
Hospitality	**69**	118
Insurance	**45**	44
Legal Fees	**173**	222
Impairments and Reversals of Receivables	**1,913**	934
Depreciation	**8,473**	8,480
Amortisation	**1,168**	1,056
Impairments and reversals of property, plant and equipment	**1,465**	1,519
Impairments and reversals of financial assets	**5,836**	1,400
Internal Audit Fees	**124**	159
Audit fees	**73**	80
Other Services: Audit Related Assurance Services	**12**	-
Clinical negligence	**12,030**	10,956
Education and Training	**965**	804
Change in Discount Rate	**78**	(5)
Other	**59**	483
Total Operating Expenses (excluding employee benefits)	**137,569**	119,160
Employee Benefits		
Employee benefits excluding Board members	**175,960**	163,346
Board members	**996**	1,173
Total Employee Benefits	**176,956**	164,519
Total Operating Expenses	**314,525**	283,679

*Services from NHS bodies does not include inter-NHS expenditure which is more suitably classified elsewhere, e.g. within Supplies and services - clinical.

NOTES TO THE ACCOUNTS

6 Employee Benefits

6.1 Employee Benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**148,593**	140,645
Social security costs	**12,793**	9,615
Employer Contributions to NHS BSA - Pensions Division	**16,051**	15,111
Other pension costs	**-**	13
Total employee benefits	**177,437**	165,384
Employee costs capitalised	**481**	865
Gross Employee Benefits excluding capitalised costs	**176,956**	164,519

6.2 Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**4**	1

6.3 Pension Costs

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is due to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with relevant stakeholders.

NOTES TO THE ACCOUNTS

7 Better Payment Practice Code

7.1 Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**83,491**	**203,731**	78,481	180,880
Total Non-NHS Trade Invoices Paid Within Target	**44,994**	**135,360**	56,052	140,505
Percentage of NHS Trade Invoices Paid Within Target	**53.89%**	**66.44%**	71.42%	77.68%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,597**	**11,586**	1,774	**15,660**
Total NHS Trade Invoices Paid Within Target	**733**	**5,135**	902	**7,243**
Percentage of NHS Trade Invoices Paid Within Target	**45.90%**	**44.32%**	50.85%	46.25%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The financial position of the Trust impacted on the 30 day performance as careful management of scarce cash resources was required all year.

NOTES TO THE ACCOUNTS

8.1 Property, Plant and Equipment

2016-17	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2016	5,485	99,705	6,816	39,007	7,694	3,344	**162,051**
Additions of Assets Under Construction			2,837				**2,837**
Additions Purchased	-	2,182	0	1,496	446	0	**4,124**
Additions - Purchases from Cash Donations & Government Grants	-	141	2,295	498	-	-	**2,934**
Additions Leased (including PFI/LIFT)	-	367	0	712	-	-	**1,079**
Reclassifications	-	7,624	(8,923)	406	808	27	**(58)**
Disposals other than for sale	-	(454)	-	(4,401)	-	-	**(4,855)**
Impairments/reversals charged to operating expenses	-	(2,804)	-	-	-	-	**(2,804)**
Impairments/reversals charged to reserves	-	(1,700)	-	-	-	-	**(1,700)**
At 31 March 2017	**5,485**	**105,061**	**3,025**	**37,718**	**8,948**	**3,371**	**163,608**
Depreciation							
At 1 April 2016	-	537	-	22,027	5,172	2,111	**29,847**
Disposals other than for sale	-	(454)	-	(3,739)	-	-	**(4,193)**
Impairment/reversals charged to reserves	-	(3,076)	-	-	-	-	**(3,076)**
Impairments/reversals charged to operating expenses	-	(1,353)	-	14	-	-	**(1,339)**
Charged During the Year	-	4,451	-	2,783	958	281	**8,473**
At 31 March 2017	**-**	**105**	**0**	**21,085**	**6,130**	**2,392**	**29,712**
Net Book Value at 31 March 2017	**5,485**	**104,956**	**3,025**	**16,633**	**2,818**	**979**	**133,896**
Asset financing:							
Owned - Purchased	5,485	76,361	3,025	10,709	2,751	919	**99,250**
Owned - Donated	-	4,859	-	1,119	67	58	**6,103**
Owned - Government Granted	-	407	-	171	-	2	**580**
Held on finance lease	-	2,108	-	4,634	-	-	**6,742**
On-SOFP PFI contracts	-	21,221	-	-	-	-	**21,221**
Total at 31 March 2017	**5,485**	**104,956**	**3,025**	**16,633**	**2,818**	**979**	**133,896**

NOTES TO THE ACCOUNTS

8.1 Property, Plant and Equipment (Continued)

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	3,755	22,036	55	313	-	9	**26,168**
Movements (specify)	-	233	-	(88)	-	(3)	**142**
At 31 March 2017	**3,755**	**22,269**	**55**	**225**	**-**	**6**	**26,310**

Additions to Assets Under Construction in 2016-17

Land	-
Buildings excl Dwellings	1,658
Dwellings	-
Plant & Machinery	1,179
Balance as at YTD	**2,837**

NOTES TO THE ACCOUNTS

8.2 Property, Plant and Equipment prior-year

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	5,240	137,230	3,523	35,691	7,050	3,344	**192,078**
Additions of Assets Under Construction			4,347				**4,347**
Additions Purchased	512	2,728		1,799	599	-	**5,638**
Additions - Purchases from Cash Donations & Government Grants	-	-	2,916	53	-	-	**2,969**
Additions Leased (including PFI/LIFT)	-	376		1,634	-	-	**2,010**
Reclassifications	-	3,346	(3,970)	579	45	-	**-**
Disposals other than for sale	-	-	-	(749)	-	-	**(749)**
Impairment/reversals charged to reserves	(267)	(16,953)	-	-	-	-	**(17,220)**
Impairments/reversals charged to operating expenses	-	(27,022)	-	-	-	-	**(27,022)**
At 31 March 2016	**5,485**	**99,705**	**6,816**	**39,007**	**7,694**	**3,344**	**162,051**
Depreciation							
At 1 April 2015	-	37,665	-	20,129	3,813	1,809	**63,416**
Disposals other than for sale	-	-	-	(749)	-	-	**(749)**
Impairment/reversals charged to reserves	-	(25,599)	-	-	-	-	**(25,599)**
Impairments/reversals charged to operating expenses	-	(15,713)	-	12	-	-	**(15,701)**
Charged During the Year	-	4,184	-	2,635	1,359	302	**8,480**
At 31 March 2016	**-**	**537**	**-**	**22,027**	**5,172**	**2,111**	**29,847**
Net Book Value at 31 March 2016	**5,485**	**99,168**	**6,816**	**16,980**	**2,522**	**1,233**	**132,204**
Asset financing:							
Owned - Purchased	5,485	75,241	3,878	11,555	2,522	1,177	**99,858**
Owned - Donated	-	387	2,938	733	-	52	**4,110**
Owned - Government Granted	-	422	-	200	-	4	**626**
Held on finance lease	-	2,040	-	4,492	-	-	**6,532**
On-SOFP PFI contracts	-	21,078	-	-	-	-	**21,078**
Total at 31 March 2016	**5,485**	**99,168**	**6,816**	**16,980**	**2,522**	**1,233**	**132,204**

NOTES TO THE ACCOUNTS

8.3 Property, Plant and Equipment (Continued)

The Trust acquired £498k (2015/16 £53k) worth of assets via Charitable Funds held by the Trust, excluding works on the Woolverstone MacMillan Centre and Dementia Wards.

Works on the Woolverstone MacMillan Cancer Centre have been part funded by donations of £1.75m from MacMillan Cancer Support; further to those received in 2015/16, from both MacMillan and the Trust Charity (£8k refunded in 2016/17). Works for the Dementia ward of £694k were fully funded by the Trust Charity.

The Trust employed the services of Gerald Eve LLP, a firm of independent valuers, to undertake a revaluation of the Trust's land and property assets as at 31 March 2017. The valuation was undertaken in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards (sixth edition) insofar as these are consistent with the requirements of HM Treasury and the Department of Health.

As a result of the revaluation £0.075m of write down in the value of Land and Buildings has been applied.

The substantial majority of buildings have been valued as specialised operational assets using the depreciated replacement cost approach on a modern equivalent asset basis. Land is valued on an existing use replacement value basis.

The valuation for operational assets was subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The gross carrying amount of fully depreciated assets still in use is £14.988m.

The minimum and maximum periods over which assets are depreciated are as follows

	Minimum	Maximum
Buildings exc Dwellings	2	68
Plant & Machinery	5	15
Information Technology	5	10
Furniture and Fittings	5	10

NOTES TO THE ACCOUNTS

9 Intangible Non-Current Assets

9.1 Intangible Non-Current Assets - Current Year

2016-17	Computer Licenses	Intangible Assets Under Construction	Total
	£000's	£000's	£000's
At 1 April 2016	**11,578**	**-**	**11,578**
Additions of Assets Under Construction	**-**	148	**148**
Additions Purchased	683	-	**683**
Reclassifications	152	(94)	**58**
At 31 March 2017	**12,413**	**54**	**12,467**
Amortisation			
At 1 April 2016	**6,205**	**-**	**6,205**
Charged During the Year	**1,168**	**-**	**1,168**
At 31 March 2017	**7,373**	**-**	**7,373**
Net Book Value at 31 March 2017	**5,040**	**54**	**5,094**

9.2 Intangible Non-Current Assets - Prior Year

2015-16	Computer Licenses	Total
	£000's	£000's
Cost or valuation:		
At 1 April 2015	10,986	**10,986**
Additions - purchased	592	**592**
At 31 March 2016	11,578	**11,578**
Amortisation		
At 1 April 2015	5,149	**5,149**
Charged during the year	1,056	**1,056**
At 31 March 2016	6,205	**6,205**
Net book value at 31 March 2016	5,373	**5,373**

9.3 Intangible Non-Current Assets

As software assets are not revalued, there is no corresponding revaluation reserve for intangible assets.

The only intangible assets held on the Trust's books are in the form of software licences purchased from third party suppliers and software developed internally. All are deemed to have a finite life. All intangible assets are held at cost and amortised at rates calculated to write them down to nil net book value over the estimated useful life of the asset.

The minimum and maximum periods over which assets are depreciated are as follows

	Minimum	Maximum
Software licenses	3	15

NOTES TO THE ACCOUNTS

10. Analysis of Impairments and Reversals Recognised in the SoCI

	2016-17 Total £000s	2015-16 Total £000s
Unforeseen obsolescence	14	12
Other	5,836	1,400
Changes in market price	1,451	1,507
Total charged to Annually Managed Expenditure	**7,301**	**2,919**
Total Impairments of Property, Plant and Equipment and Financial Assets charged to SoCI	**7,301**	**2,919**
Total Impairments charged to SoCI - DEL	**-**	**-**
Total Impairments charged to SoCI - AME	**7,301**	**2,919**
Overall Total Impairments	**7,301**	**2,919**

The Trusts Estate was valued as at 31 March 2017 by the Trusts valuers (Gerald Eve LLP), resulting in impairments totalling £1,451k.

As at 1 April the value of the Trusts investment in The Pathology Partnership was £1,400k. During 2016/17 the Trust increased its investment by £4,554k to £5,836k. The fair value of the investment as at 31 March 2017 was £nil, resulting in an impairment of £5,836k.

The above impairments have been classified as AME. AME Impairments are not included within the Trusts Reported Performance against the Breakeven Target (note 22.1)

NOTES TO THE ACCOUNTS

11.1 Trade and Other Receivables

	Current		Non-Current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS receivables - revenue	**6,829**	5,064	-	-
NHS prepayments and accrued income	**11,472**	3,789	-	-
Non-NHS receivables - revenue	**4,708**	3,096	-	-
Non-NHS prepayments and accrued income	**5,935**	3,765	-	-
PDC Dividend prepaid to DH	**95**	177	-	-
Provision for the impairment of receivables	**(2,930)**	(1,406)	-	-
VAT	**612**	459	-	-
Other receivables	**1,245**	1,351	**1,410**	821
Total	**27,966**	16,295	**1,410**	821
Total current and non current	**29,376**	17,116		

The great majority of trade is with Clinical Commissioning Groups and NHS England. As both are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Receivables which are neither past their due date nor impaired are considered to be of acceptable credit quality.

11.2 Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**8,256**	1,908
By three to six months	**525**	884
By more than six months	**462**	678
Total	**9,243**	3,470

Of the unimpaired receivables, £2,521k are non-NHS, of which £90k are more than 3 months past their due date.

NOTES TO THE ACCOUNTS

12 Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**879**	153
Net change in year	**64**	726
Closing balance	**943**	879
Made up of		
Cash with Government Banking Service	**939**	875
Cash in hand	**4**	4
Cash and cash equivalents as in statement of financial position	**943**	879
Cash and cash equivalents as in statement of cash flows	**943**	879

NOTES TO THE ACCOUNTS

13 Trade and Other Payables

	31 March 2017 £000s	31 March 2016 £000s
NHS payables - revenue	**3,724**	2,357
NHS accruals and deferred income	**3,253**	2,475
Non-NHS payables - revenue	**13,062**	9,810
Non-NHS payables - capital	**453**	2,304
Non-NHS accruals and deferred income	**16,108**	15,756
Social security costs	**1,885**	1,496
Accrued Interest on DH Loans	**137**	57
Tax	**1,663**	1,635
Payments received on account	**33**	3
Other	**78**	138
Total payables	**40,396**	36,031
Included above:		
Outstanding Pension Contributions at the year end	**2,227**	2,178

14 Borrowings

	Current		Non-Current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Loans from Department of Health	**-**	-	**48,802**	19,050
PFI liabilities - main liability	**800**	772	**19,953**	21,143
Finance lease liabilities	**671**	540	**5,111**	5,144
Total	**1,471**	1,312	**73,866**	45,337
Total other liabilities (current and non-current)	**75,337**	46,649		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	Other £000s	Total £000s
0-1 Years	-	1,471	**1,471**
1 - 2 Years	17,324	1,530	**18,854**
2 - 5 Years	31,478	5,657	**37,135**
Over 5 Years	-	17,877	**17,877**
TOTAL	**48,802**	**26,535**	**75,337**

NOTES TO THE ACCOUNTS

15 Finance Lease Obligations as Lessee

The Trust has a variety of financial leases for equipment and demountable buildings. These leases do not include any clauses in respect of renewal, purchase or escalation and any such issues to be dealt with by negotiation at the end of the primary lease period.
No restrictions are placed on the Trust by the leases other than to return the assets in working condition at the end of the lease period.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**146**	146	**89**	84
Between one and five years	**585**	585	**409**	387
After five years	**585**	731	**510**	621
Less future finance charges	**(308)**	(370)	**-**	-
Minimum Lease Payments / Present value of minimum lease payments	**1,008**	1,092	**1,008**	1,092
Included in:				
Current borrowings			**89**	84
Non-current borrowings			**919**	1,008
			1,008	1,092

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**807**	733	**582**	456
Between one and five years	**3,190**	2,921	**2,578**	2,150
After five years	**1,800**	2,281	**1,614**	1,986
Less future finance charges	**(1,023)**	(1,343)	**-**	-
Minimum Lease Payments / Present value of minimum lease payments	**4,774**	4,592	**4,774**	4,592
Included in:				
Current borrowings			**582**	456
Non-current borrowings			**4,192**	4,136
			4,774	4,592

NOTES TO THE ACCOUNTS

16 Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**1,411**	254	55	1,102
Arising during the year	**445**	10	31	404
Utilised during the year	**(308)**	(48)	(21)	(239)
Reversed unused	**(35)**	(2)	-	(33)
Unwinding of discount	**14**	3	-	11
Change in discount rate	**78**	7	-	71
Balance at 31 March 2017	**1,605**	**224**	**65**	**1,316**
Expected Timing of Cash Flows:				
No Later than One Year	**568**	41	64	463
Later than One Year and not later than Five Years	**368**	127	-	241
Later than Five Years	**669**	56	1	612

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

	£000
As at 31 March 2017	**211,241**
As at 31 March 2016	169,800

The value and expected timings of the public and employers liability (legal claims) and injury benefit provisions (other) are calculated by reference to information, available at the reporting date, provided by the Trust's legal advisors. As new evidence comes to light, the value of the provision can change either up to down. Similarly, new evidence can affect the expected timing of the cash flows.

The provision for early departure costs represents the actuarial liability for staff who took early retirement before 6 March 1995. This is settled by a quarterly charge from the NHS Pensions Agency.

Included in Amounts Arising During the Year - Other Provisions, is £200k in respect of the Pathology Partnership, for estimated losses not covered by Partner funding as at 31 March 2017.

NOTES TO THE ACCOUNTS

17 PFI and LIFT - additional information

The Trust has no LIFT contracts
The Trust has no off SOFP PFI contracts

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

	2016-17 £000s	2015-16 £000s
Service element of on SOFP PFI charged to operating expenses in year	**807**	799
Total	**807**	799

Payments committed to in respect of the service element of on SOFP PFI

No Later than One Year	**791**	772
Later than One Year, No Later than Five Years	**3,164**	3,087
Later than Five Years	**11,074**	11,576
Total	**15,029**	15,435

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2016-17 £000s	2015-16 £000s
No Later than One Year	**1,597**	1,597
Later than One Year, No Later than Five Years	**7,067**	6,841
Later than Five Years	**20,887**	23,100
Subtotal	**29,551**	31,538
Less: Interest Element	**(8,798)**	(9,623)
Total	**20,753**	21,915

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2016-17 £000s**	2015-16 £000s
No Later than One Year	**800**	772
Later than One Year, No Later than Five Years	**4,200**	3,836
Later than Five Years	**15,753**	17,307
Total	**20,753**	21,915

Number of on SOFP PFI Contracts

Total Number of on SOFP PFI contracts	**1**

The Trust has a PFI agreement in place with Prospect Healthcare Limited in respect of the Garrett Anderson Centre, a building that houses the Trust's Accident & Emergency Unit, Intensive Care Unit, Day Surgery Unit and a 40 bedded Ward. This fixed 30 year term agreement covers the design, build and maintenance of the building to a set standard for the duration of the contract at the end of which the building will revert to the Trust's freehold ownership.

Prospect Healthcare Limited receive a single unitary payment to cover all the elements of the facility that they are contracted to provide. This unitary payment was fixed at the start of the contract and its value is indexed on an annual basis using a pre-specified agreed National Index. Any variations to the contract in terms of changes to the specification of the building go through a formal change control process with a clearly specified methodology for calculation of the financial impact, both in the current period and over the remaining life of the contract.

Failure to provide the accommodation in terms of availability and quality results in a reduction in the unitary payment until the failure is rectified.

The contract for the agreement commenced on 28 March 2006 and is for a period of 30 years. The estimated capital value of the scheme at inception was £29.084 million.

NOTES TO THE ACCOUNTS

18 Impact of IFRS treatment

	Expenditure 2016-17 £000s	Expenditure 2015-16 £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	**481**	475
Interest Expense	**825**	1,637
Impairment charge - AME	**(256)**	175
Other Expenditure	**2,228**	1,548
Impact on PDC dividend payable	**(6)**	(42)
Total IFRS Expenditure (IFRIC12)	**3,272**	**3,793**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**3,825**	3,756
Net IFRS change (IFRIC12)	**(553)**	**37**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2016-17	352	319
UK GAAP capital expenditure 2016-17 (Reversionary Interest)	320	320

	2016-17 Income/ Expenditure IFRIC 12 YTD £000s	**2016-17 Income/ Expenditure ESA 10 YTD £000s**	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	2015-16 Income/ Expenditure ESA 10 YTD £000s
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**481**	-	475	-
Interest Expense	**825**	-	1,637	-
Impairment charge - AME	**(256)**	-	175	-
Impairment charge - DEL	-	-	-	-
Other Expenditure				
Service Charge	**806**	**3,825**	766	3,756
Contingent Rent	**680**	-	782	-
Lifecycle	**742**	-	-	-
Impact on PDC Dividend Payable	**(6)**	-	(42)	-
Total Revenue Cost under IFRIC12 vs ESA10	**3,272**	**3,825**	**3,793**	**3,756**
Revenue Receivable from subleasing	-	-	-	-
Net Revenue Cost under IDRIC12 vs ESA10	**3,272**	**3,825**	**3,793**	**3,756**

NOTES TO THE ACCOUNTS

19 Financial Instruments

19.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with CCGs and NHS England and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its Capital Resourse Limit. The Trust is not, therefore, exposed to significant liquidity risks.

19.2 Financial Assets

	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s
Receivables - NHS	18,296	-	**18,296**
Receivables - non-NHS	5,397	-	**5,397**
Cash at bank and in hand	943	-	**943**
Total at 31 March 2017	**24,636**	**-**	**24,636**
Receivables - NHS	8,996	-	8,996
Receivables - non-NHS	4,628	-	4,628
Cash at bank and in hand	879	-	879
Other financial assets	-	1,282	1,282
Total at 31 March 2016	14,503	1,282	15,785

NOTES TO THE ACCOUNTS

19.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	5,949	**5,949**
Non-NHS payables	28,682	**28,682**
Other borrowings	48,802	**48,802**
PFI & finance lease obligations	26,534	**26,534**
Total at 31 March 2017	**109,967**	**109,967**
NHS payables	3,777	3,777
Non-NHS payables	28,911	28,911
Other borrowings	19,050	19,050
PFI & finance lease obligations	27,599	27,599
Total at 31 March 2016	79,337	79,337

20 Events after the end of the reporting period

There were no events after the the end of the reporting period.

21 Related Party Transactions

During the year none of the Department of Health Ministers, Ipswich Hospital NHS Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party, and parent Department of Ipswich Hospital NHS Trust. During the year Ipswich Hospital NHS Trust had material transactions with the Department, and with other entities for which the Department of Health is regarded as the parent Department. The Trust considers material transactions to include those individually or in aggregate exceeding £100,000. The entities which the Trust had material transactions during the year are as follows.

CCGs
Cambridgeshire And Peterborough CCG
Great Yarmouth And Waveney CCG
Ipswich And East Suffolk CCG
Mid Essex CCG
North East Essex CCG
South Norfolk CCG
West Suffolk CCG
NHS England Bodies
NHS England Core
East Local Office
East Midlands Specialised Commissioning Hub
East of England Specialised Commissioning Hub
NHS Foundation Trusts
Cambridge Univ Hosp NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Norfolk And Norwich University Hospitals NHS Foundation Trust
Norfolk And Suffolk NHS Foundation Trust
Oxford Health NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Southend University Hospitals NHS Foundation Trust
West Suffolk NHS Foundation Trust
NHS Trusts
Cambridgeshire Community Services NHS Trust
East of England Ambulance Service NHS Trust
Norfolk Community Health and Care NHS Trust
Other Bodies
Department of Health
Public Health England
NHS Litigation Authority
Health Education England
NHS Blood and Transplant

NOTES TO THE ACCOUNTS

21 Related party transactions (Continued)

Various departments within the Trust also received revenue and capital payments from a number of Charitable Funds for which the Trust is the Corporate Trustee. These payments amounted to £1,530k (2015/16 £604k). The Trust provides administrative and management services to the Charitable Funds for which a charge of £54k (2015/16 £35k) (reflecting actual costs) has been made for the 2016/17 financial year. At 31 March 2017 the Charitable Funds owed £68k (31 March 2016: £20k) to the Trust.

NOTES TO THE ACCOUNTS

22 Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

22.1 Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	182,029	194,373	207,965	225,962	235,136	238,150	236,732	249,439	250,597	266,310	296,451
Retained surplus/(deficit) for the year	1,025	5,037	4,580	(5,263)	1,260	729	787	749	(11,244)	(22,263)	(22,340)
Adjustment for:											
Timing/non-cash impacting distortions:											
Prior Period Adjustments	-	(627)	-	-	-	-	-	-	-	-	-
Adjustments for impairments	-	-	-	2,356	-	(592)	167	333	(834)	2,919	7,301
Adjustments for impact of policy change re donated/government grants assets	-	-	-	-	-	-	(749)	(1,032)	185	(2,754)	(2,539)
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	-	-	-	6,258	-	-	-	-	-	-	-
Break-even in-year position	**1,025**	**4,410**	**4,580**	**3,351**	**1,260**	**137**	**205**	**50**	**(11,893)**	**(22,098)**	**(17,578)**
Break-even cumulative position	**(17,346)**	**(12,936)**	**(8,356)**	**(5,005)**	**(3,745)**	**(3,608)**	**(3,403)**	**(3,353)**	**(15,246)**	**(37,344)**	**(54,922)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.56	2.27	2.20	1.48	0.54	0.06	0.09	0.02	(4.75)	(8.30)	(5.93)
Break-even cumulative position as a percentage of turnover	(9.53)	(6.66)	(4.02)	(2.21)	(1.59)	(1.52)	(1.44)	(1.34)	(6.08)	(14.02)	(18.53)

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

NOTES TO THE ACCOUNTS

22.2 Capital Cost Absorption Rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

22.3 External Financing

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

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	**29,303**	17,590
Cash flow financing	**28,295**	15,535
Finance leases taken out in the year	**712**	1,634
External financing requirement	**29,007**	17,169
Under spend against EFL	**296**	421

22.4 Capital Resource Limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	**11,805**	15,555
Less: book value of assets disposed of	**(662)**	-
Less: donations towards the acquisition of non-current assets	**(2,934)**	(2,968)
Charge against the capital resource limit	**8,209**	12,587
Capital resource limit	**8,274**	12,927
Underspend against the capital resource limit	**65**	340

The Ipswich Hospital
NHS Trust

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

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This Trust is working towards equal opportunities.

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