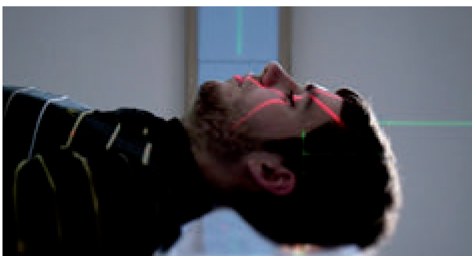
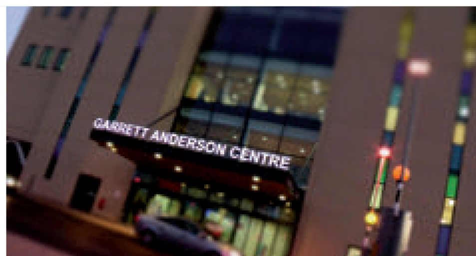
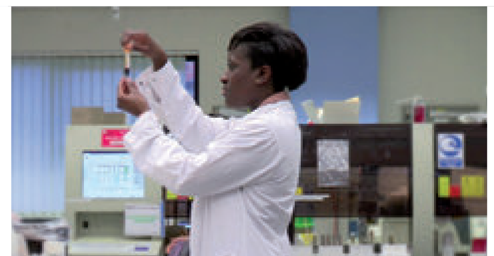
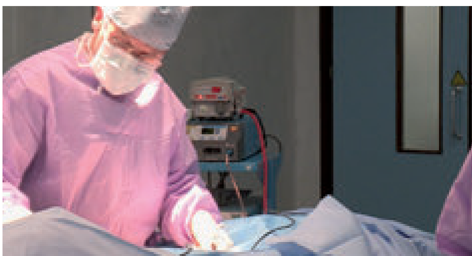
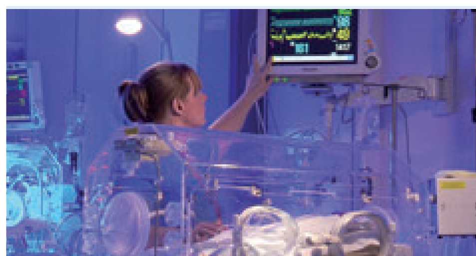
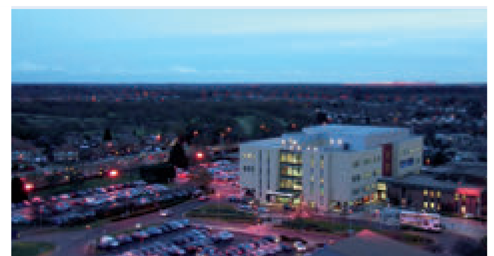
The Ipswich Hospital NHS

NHS Trust

Discover Ipswich Hospital...

Annual Report and Accounts 2012/13

Our Passion, Your Care.

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

Polish język polski

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

Portuguese Português

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

Chinese 中文

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

Bengali বাংলা

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

Kurdish کوردی

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

Farsi فارسی

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

Contents

Welcome 3
Chair's Foreword 4
Chief Executive's Overview 5

What We Need To Tell You 6
Background and Context 6
Key Relationships 13
Sustainability Report 17
Structure and Management 19

Performance and Accounts 25
Performance 25
Operating Financial Review 28
Our Accounts 30
Remuneration Report 38
2012/13 Governance Statement 42
Declaration of Interests 2012/13 51

Glossary of Terms 53

Thank You To 54

This Annual Report has been prepared in accordance with the requirements set out in the 2012/2013 NHS Trust Manual for Accounts.

The Quality Account 2012/13 is a companion document to this report and is available on line at www.ipswichhospital.nhs.uk

Welcome

Chair's Foreword

I am very pleased to introduce this annual report, at the end of my first year as Chair, and in particular to highlight just a few of the outstanding achievements made possible by the hard work and dedication of all our staff and volunteers who make up the Ipswich Hospital NHS Trust.

Ann Tate CBE,
Chair.

The past year has been particularly turbulent in the light of the significant changes being introduced across the whole NHS in England and these will continue to resonate in the coming year. In that context it is therefore doubly gratifying to be able to point to a wide range of success across all our clinical areas.

Most notably it has been a year in which our maternity services were awarded the national accolade of Maternity Unit of the Year 2013 by the Royal College of Midwives.

We have successfully planned, built and delivered a major new heart centre, and a sterile services department, on time and on budget. These developments which cost £10.8 million will make a real difference to patients and allow us to deliver services closer to home for the community we serve.

The Care Quality Commission, who regulate standards in all health and social organisations, inspected the hospital and gave us a completely clean bill of health – a testament to the hard work of staff in improving quality, involving patients and family carers in treatment and care programmes, and raising the bar on patient experience.

There was excellent feedback too from patients using the Emergency Department who rated the service well above the national average. The Emergency Department team's expertise was acknowledged by being given Trauma Unit status this year.

Our hospital's skin cancer care is among the best in the country. A review of services this year shows the hospital shares top fourth spot in the UK. Another top rating was given by Dr Foster, an information analyst company independent from the NHS, who rated us in the top six in the country for clinical efficiency.

And there's more. We're working with national charity The King's Fund to improve the care we give to dying patients and their families, and are one of the first in the country to sign up for a call for action to improve care in hospitals for patients with dementia.

We've continued to deliver safe, compassionate care despite much intense pressure on services particularly the Emergency Department throughout the year.

We are a strong hospital confident of the future, thanks in no small part to the tremendous support we receive from our community, our Members of Parliament, shadow governors, local and regional councillors and of course our partners and commissioners of care.

My thanks to you all.

Ann Tate CBE
Chair
31 March 2013

Chief Executive's Overview

This is my first annual report and I am delighted to give this overview. I am really pleased to be part of what is clearly a team of outstanding people committed to improving the lives of the community we serve.

Nick Hulme,
Chief Executive.

I have inherited a legacy of exceptional leadership. Nigel Beverley was the interim chief executive of the hospital for 11 months, taking over from Andrew Reed who had led the hospital for almost seven years before that.

What we are starting to do now is build on this and really develop clinical leadership with clinicians at the heart of the organisation supported by highly skilled managers and support staff.

The NHS faces significant challenges and scrutiny that won't go away as we move into the next period of our developments.

What's clear is that we need to do things differently. Our new clinical strategy sets out how we think we can deliver safe, compassionate care centred around the patient. This will mean a departure from tradition, with more specialist care being delivered in GP surgeries and health centres and one visit to hospital for patients for all the tests they need.

We will need to change the way the hospital works, including the buildings to deliver this. Form follows function so we will need to review the hospital site and potentially change the estate to deliver this.

The £10.8 million investment programme that we have had this year to build a new cardiology centre and sterile services department will make a fantastic contribution to the work of the hospital. Of course, buildings don't by themselves make the difference it is the people who work within them.

The hospital has positive and good relationships with the clinical commissioning groups, local authorities and the voluntary sector, together with external partners, all of whom are concerned with making genuine improvements in health and social care for people when they become unwell. By working collaboratively we can make real and sustained improvements to people's health and wellbeing.

I want this hospital to be one that everyone can be proud of, the patients we treat, the staff and volunteers who work here and the community we serve. When we get it wrong, we need to know about it so we can get it right the next time. I have only been here a short time but I am very proud of the hospital and I know that we can become an outstanding centre of care.

Nick Hulme
Chief Executive
31 March 2013

What We Need To Tell You

Background and Context

The Ipswich Hospital NHS Trust is a National Health Service Trust providing hospital-based health care to more than 443,000 people who live in and around Ipswich and east Suffolk. The Secretary of State for Health approved Trust status for Ipswich Hospital in April 1993.

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

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

We are a safe hospital, with a low standardised mortality rate.

The hospital has 554 beds (as of 31 March 2012) in general acute, maternity, paediatric and neonatal services and had an annual turnover of £238 million in 2011/12. Across its 46-acre site, we employ just over 3,700 whole-time equivalent NHS staff.

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

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

A changing landscape

The Health and Social Care Act 2012 is the most extensive re-organisation of the structure of the NHS in England to date. It sets out a new system for the NHS and, specifically, the establishment of a new commissioning system.

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 Suffolk NHS QIPP Forum to take forward Suffolk's healthcare priorities.

Our Maternity Services team won the
Royal College of Midwives' Maternity Service of the Year Award 2013.

Background and Context

We have had a mission to provide care and prevent ill health since we were founded, but the environment around us has changed enormously, and will continue to change. We must respond to these changes – in the population's needs and expectations, in technology and in the economics underpinning healthcare.

Our response will include changes in the way we look after our patients. We know that because people are living longer, many more will need treatment for conditions like cancer and heart disease. There are great research developments on the horizon which mean that we can do much more for our patients with cancer and blood disorders, for example. And we know that if we organise ourselves differently, much of the care our patients need could be provided closer to their homes. We must find ways of delivering services that will not only satisfy our patients, but will also reduce costs for the health system as a whole.

The Trust has undertaken a review of the healthcare environment that it is operating within which included the following.

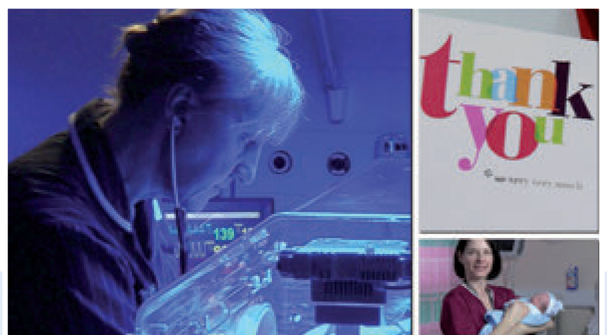
The impact of rising demand, demographic changes and the costs of new drugs and technologies means that the NHS will need to deliver efficiency savings of up to £20 billion in the coming years whilst improving the quality of a comprehensive service on offer to patients. For us, this results in the need to make productivity gains of at least 4% each year at least until the end of 2018. Whilst some of this will be achieved through operational efficiencies (and all such opportunities are being pursued), these measures will not by themselves be sufficient to address the efficiency gap for the Trust. Ensuring the sustainability of high quality acute services will require transformational change within acute services and across the other local healthcare providers.

Our Mission and Vision

The Ipswich Hospital NHS Trust has embarked upon an exciting and challenging journey to achieve a new vision and strategy for the future. Over the next few years, significant challenges will affect all parts of the NHS. It is our strong belief that many acute hospital services will only be sustainable when provided for larger populations than currently, probably in partnership with other providers.

Our mission is:

> "to continue to provide care and prevent ill health by moving towards being at the centre of a network of services for the county of Suffolk and parts of north east Essex, working with partners, operating from a wider health campus, providing co-located and integrated services and fostering education, teaching and research."



About 500 babies a year need specialist care in our Neonatal Unit.

Background and Context

We want to be judged by the quality of care we provide to those who choose to use our services, both now and in the future.

Our commitment to high quality patient care delivery is encapsulated in a simple statement "Our passion, your care".

Vision for the Future

Our vision for the future is, to be at the centre of a networked provision of healthcare services to the population of Suffolk and north east Essex.

The rationale for our vision is outlined below:

- Sustainability of small to medium sized DGHs will only be achieved by partnerships and networked service provision with the move to 24/7 consultant-led services and workforce constraints.
- Ipswich Hospital provides a range of local specialist healthcare services.
- We have a wide range of skilled staff.
- We promote education and training and foster research locally to support our status as a teaching hospital affiliated to the University of Cambridge, the University of East Anglia and University Campus Suffolk.

In the shorter term, our plan is to take incremental steps to achieve the longer term vision by:

- Enhancing the provision of healthcare services by creating local specialists centres.
- Delivering integrated models of care with Community Providers, and local Commissioners, consistent with Care Closer to Home.
- Developing strategic alliances with other acute provider organisations to promote improved quality of care and best value through partnership working.
- Developing multiprofessional education, training and research and achieve University Hospital status by working with local higher education providers.

We recognise that delivery of our vision will be challenging, and will only be achieved through partnership working, but it is aimed at ensuring high quality sustainable healthcare services for the future for our catchment population.

Our values are:

Respect and dignity

We value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

Commitment to quality of care

We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communications. We welcome feedback, learn from our mistakes and build on our success.

Our Pathology department includes Haematology, Clinical Biochemistry, Microbiology, Cytology and Histology.

Background and Context

Compassion

We respond with humanity and kindness to each person's pain, distress, anxiety or need.

Improving lives

We strive to improve health and wellbeing and people's experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

Working together for patients

We put patients first in everything we do by reaching out to staff, patients, carers, families, communities and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

Everyone counts

We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken and that when we waste resources we waste others opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

Our five key objectives are to have:

- Excellent outcomes: clinical, and research;
- Excellent experience: for patients, staff and GPs;
- Excellent value: improving efficiency and productivity and reducing costs;
- Full compliance: meeting or exceeding all regulatory and outcome standards; and

To be:

- A strong organisation, effectively investing in our staff and our infrastructure to ensure that we are fit for the future.

Looking to the future

The Trust Board has agreed that Patient Safety is paramount in its importance and is therefore integral in everything that we do. As such, the Board has agreed that nothing we do, in the furtherance of the achievement of any of our objectives, must in any way compromise the safety of patients.

We have developed six over-arching strategic objectives to support realisation of our vision:

1. Be in the top 10% of healthcare providers for providing an excellent patient experience, harm-free and with positive clinical outcomes.
2. Be the first-choice provider of local healthcare services.
3. Continue to develop local specialist centres (eg Oncology/ Radiotherapy, and Cardiac Services) and continue to foster innovation and change in all service delivery to ensure clinical excellence.

Each year, our Pathology service provides 5 million test results.

Background and Context

4 Develop innovative integrated care, so that patients only visit the hospital when necessary, eg patients suffering long term conditions.

5 Be in the top 20% of hospitals assessed against Staff Net Promoter Indicators.

6 Achieve a year-on-year surplus to reinvest in improving services.

We will take into account the current economic and financial challenges.

Quality

Our approach to quality is based on patient safety, clinical effectiveness and patient experience.

Each year we produce a Quality Account, which is warmly welcomed by staff as it gives the hospital one central place to bring together all the different sorts of information which is currently collected. It makes the information much more meaningful and helps staff take immediate action to address issues identified.

The hospital has set itself the following priorities to improve quality which are:

- To minimise in-hospital harm to patients from pressure ulcers, falls, urinary tract infections from catheters and venous thromboembolism (VTE) by working towards above benchmarked standards for 'harm-free care';
- To reduce the numbers of patients readmitted within 30 days with a condition associated with their previous episode of care, in comparison to 2012/13 by 31 March 2014;
- To reduce amenable mortality levels in line with benchmark data ("amenable" mortality is defined as deaths that were potentially preventable by direct, timely and appropriate medical care);
- To develop organisational values which are understood, owned and underpin the behaviours of all Trust staff.

  Ensuring that these are embedded will be measured through; a baseline cultural survey comparison to a follow-up survey, National Staff Survey results, patient experience data (complaints, compliments, friends and family test – net promoter score for staff and patients).
- Improvement in the net promoter score (otherwise known as the 'friends and family test' who would recommend Ipswich Hospital as a place of treatment to their friends and family) for patients receiving care as inpatients, in the Emergency Department and as outpatients.

The Quality Report 2012/13 is available from late June 2013.

Our state-of-the-art Pharmacy robots can sort and store 30,000 packs of drugs.

Background and Context

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. Every hospital is monitored to make sure they continue to meet essential standards of quality and safety. Ipswich Hospital was visited by the CQC in July 2012 and was found to be meeting all the essential standards of quality and safety inspected.

NHSLA

The NHSLA is the litigation authority which works to improve risk management practices in the NHS. Every NHS hospital is visited by independent assessors once every 2–3 years, and this includes visits to wards, looks at how we manage clinical risk and informs the premium we pay for clinical negligence claims. In February 2011 we were accredited at NHSLA level 2. We had previously attained level 1 accreditation so we are very pleased to have reached this higher status.

National policies and priorities

The Department of Health's Operating Framework 2012/13 sets out a number of requirements for all NHS organisations and highlights the need to:

- maintain and improve the quality of services, building on success to date;
- retain financial control and meet the quality and productivity challenge; and
- to make progress on the transition to new arrangements.

Local context

NHS Ipswich and East Suffolk Clinical Commissioning Group (the CCG) is a group of 42 GP practices in Ipswich and the eastern part of Suffolk.

From 1 April 2013, the CCG became responsible for commissioning (buying-in) and managing healthcare services once the local primary care trust, NHS Suffolk, ceased to exist. The CCG was established in April 2012 and has responsibility for approximately 385,000 patients. The CCG is expected to have funding of £425m to commission healthcare services each year.

The Governing Body of the CCG includes seven local GPs from across the Ipswich and east Suffolk area. Additionally, the Governing Body includes a secondary care doctor (who has to be from out of the area), a 'patient and public involvement' lay member and an 'audit and governance' lay member.

Local GPs understand what their patients need. Having GPs from Ipswich and east Suffolk in charge of the local healthcare budget means they will hold the purse strings. This will ensure we make the right decisions on buying and managing health services and make a real difference to the community's health and wellbeing.

We carry out over 15,000 operations in theatres a year.

Background and Context

Ipswich and East Suffolk CCG (I&ESCCG) overarching aims are to:

- work effectively with patients, carers, communities, clinicians and partners;
- improve the health and wellbeing of the people of Suffolk;
- help individuals to take responsibility for their health;
- ensure high quality health services for all who need them;
- give patients and their carers easy access to joined-up services; and
- maintain financial balance.

Specifically the CCG's priorities are to:

- improve health and educational attainment for children and young people;
- improve outcomes for patients with diabetes to above national average;
- improve care for frail, elderly individuals;
- improve access to mental health services;
- allow patients to die with dignity and compassion, and choose their place of death;
- improve the health of those most in need;
- ensure high quality local services wherever possible; and
- promote self-care.

Over 100 patients a day are treated in our Radiotherapy department.

Key Relationships

Staff

We have over 3,700 members of staff (3,113 WTE) and around 500 volunteers all working together to provide safe and caring services to our patients. There is a new structure within the hospital, enabling more clinicians to be involved in the decisions being taken and providing the direction and steer to enable the continued success of the organisation.

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

Equality and fairness, and recognising diversity within our community and staff are always at the heart of the services we provide. Our staff are actively involved in promoting health and wellbeing within the workplace, with some keen promoters of fitness volunteering to be trained as running coaches to establish for the first time 'The Ipswich Hospital Running Club', primarily aimed at newcomers to running, encouraging staff to be active, fit and look after themselves. With a sickness absence rate for 2012/13 of 4.5%, we are keen to do all we can to provide support and guidance to staff on their health and wellbeing. We continue with our successful programme of health and wellbeing activities and promotional events for staff, which have been warmly received with requests for more!

- To improve access to healthcare and health outcomes of older people and those with learning disabilities.
- To improve services for protected groups by collecting and making use of effective equality data.
- To ensure all protected groups are truly represented and closely engaged with, so that the Trust is able to respond appropriately to both the clinical and non-clinical needs of patients and carers.
- To develop a formal support structure and leadership programme for middle managers within the Trust.

We continue to invest in the training and education of all our staff, and have a dedicated Postgraduate Education Centre on site, working closely with the local universities in East Anglia, with some of our staff teaching on programmes of higher education.

With a new Chief Executive at the helm, this is an exciting time for the hospital, to build on the successes and challenges of 2012/13 and continue to drive forward a transformation programme ensuring that our patients and staff are at the heart of the services we provide.

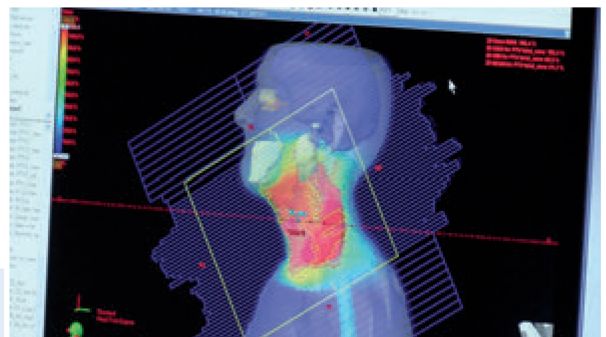


Image from our £2million state-of-the-art Truebeam radiotherapy machine.

Key Relationships

Patients

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

A Patient Experience Group which includes patient representatives who voice the views of patients, their families and visitors, is now well-established and has made several thought-provoking films. The key principles of our Patient Experience work are:

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

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

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

There are 14 user groups covering both specific conditions, for example, cancer and diabetes, and addressing wider issues such as disability and diversity.

During intensive weeks, our Physiotherapy service can see up to 560 patients.

Key Relationships

Members are patients, carers and representatives from community partners such as Age UK. More than 150 people are actively involved in these groups and provide insight to enable the patient and carer perspective and experience to influence the development and provision of services.

The hospital already collates patient feedback in a number of ways including inhouse and national patient surveys, monitoring of complaints and compliments and 'Your Views Matter' comment cards on wards.

iPads (hand-held digital devices) are also capturing patients' feedback, which is collected separately for each area and displayed outside the department's entrance each month.

The hospital was part of the East of England's pilot for the 'friends and family' test survey which has now been rolled out nationally and will provide patients with the opportunity to say whether they would recommend this hospital to their friends and family.

Community

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

Key strategic alliances

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

We employ just over 3,400 staff. Some are internationally renown.

Key Relationships

Sustainability

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

The Trust uses the Premises Assurance Model when this is available as a rigorous self-assessment tool to enable the Trust to certify that its premises achieve the required statutory and NHS nationally agreed standards.

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

The sustainable key actions are as follows:

- The Trust has developed a Carbon Reduction Plan to achieve at least a 20% reduction in emissions in line with government national targets for the NHS.
- The Trust has calculated its carbon footprint.
- An action plan of projects has been developed to deliver the required carbon reduction targets.
- A Sustainable Development Management Plan has been introduced.
- The Trust has signed up to the Good Corporate Citizen Assessment Test and is developing an action programme based upon the results.
- The Trust carries out benchmark comparisons against similar Trusts.
- The Trust will continue to work with the Carbon Trust and other sustainable organisations.

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

Nurses around the world – including here at Ipswich – are celebrated every year on May 12, the anniversary of Florence Nightingale's birth.

Sustainability Report

1%

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill. Major developments such as the new Cardiology Unit and HSDU and the introduction of new equipment such as in Diagnostic Imaging (X-ray) meant a rise of 1% in our overall energy use and carbon emissions. The Trust is still on target, however, to achieve the reductions stated.

£1,228,860 potential savings

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 15 years we expect to save £1,228,860 as a result of these measures.

1202 tonnes of waste recovery

We recover or recycle 1202 tonnes of waste, which is 98% of the total waste we produce.

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

Year	Type	Amount
2011/12	Clinical Waste incineration	£108,748
	Domestic Waste	£63,815
2012/13	Clinical Waste incineration	£106,303
	Domestic Waste	£62,694

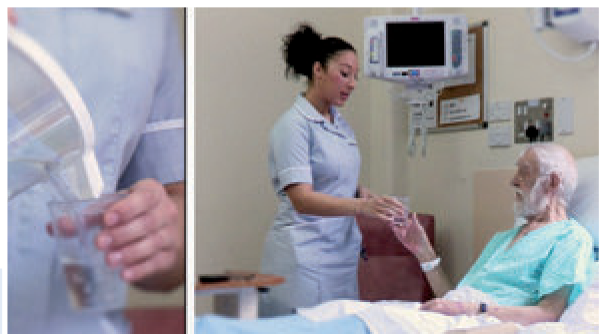
Energy consumption

Our total energy consumption has risen during the year, from 27,727 to 29,369 MWh, however our relative energy consumption has changed during the year, from 0.32 to 0.29 MWh / square metre.

We supply 60% of our space heating from renewable sources; 10% of our supplied electricity is from renewable sources.

Our measured greenhouse gas emissions have increased by 480 tonnes this year.

Our water consumption has reduced by 1632 cubic meters in the recent financial year. In 2012/13 we spent £276,709 on water.



Healthcare assistants play a vital role in patient safety and care.

Sustainability Report

CRC payment

The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. During 2012/13 our gross expenditure on the CRC Energy Efficiency Scheme was £129,276 which was slightly lower than the initial predicted amount.

Travel costs

During 2012/13 our total expenditure on business travel was £28,000.

Sustainable Management

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

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

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

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

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

The Chief Operating officer is the Board Level Lead for Sustainability. A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation. Sustainability issues, such as carbon reduction, are included in the job descriptions of all staff. "A sustainable NHS can only be delivered through the efforts of all staff."

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

Haughley Ward has special signage and decor to help patients.

Structure and Management

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

Chair and Non-Executives	
Ann Tate CBE	Chair (from 02/04/2012)
Julia Holloway	Non-Executive Director
Alan Bateman	Non-Executive Director
Tony Thompson	Non-Executive Director
Andrew George	Non-Executive Director
Dave Norval	Non-Executive Director (until 31/12/2012)

Ann Tate CBE, took up her new appointment as Trust Chair on 2 April 2012.

All non-executive director appointments up to 30th September 2012 were made through the Appointments Commission. Responsibility for non-executive director appointments transferred to the NHS Trust Development Authority from 1st October 2012.

The Chair and all non-executive directors are members of the Trust Board, and Remuneration Committee.

All the non-executive directors are members of the Audit Committee. Membership does not include the Trust Chair.

The Audit Committee's membership is all of the non-executive directors. The Chief Executive and Director of Finance and Performance are attendees at each meeting as well as external and internal auditors.

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

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

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

The Chief Executive and Executive Directors were appointed using open competition and a selection process. They were appointed on a permanent basis and are subject to annual performance reviews, Trust policies and procedures. During the year 2012/13, three interim directors were appointed, Nigel Beverley as interim chief executive from May 2012 until 31 March 2013, Margaret Blackett as interim director of transformation (and later this included operations) from July 2012, and Mary Leadbeater as interim director of finance from 24 September 2012. Paul Scott has been appointed the substantive director of finance and joins the Trust on 3 June 2013. A substantive chief operating officer Neill Moloney has also been appointed and joins the Trust in July 2013.

Details of directors remuneration are given on page 39 of this report.

Structure and Management

Trust Executive Directors		
Andrew Reed	Chief Executive	Left the Trust on 18/05/2012
Nigel Beverley	Interim Chief Executive	Commenced on 21/05/2012 Left the Trust on 31/03/2013
Peter Donaldson	Trust Medical Director	Tenure as Medical Director ended on 31/03/2013
Siobhan Jordan	Director of Nursing and Quality, Infection Prevention and Control	Left the Trust on 17/06/2012
Catherine Morgan	Interim Director of Nursing and Quality, Infection Prevention and Control	18/06/2012 to 12/08/2012
Lynne Wigens	Director of Nursing and Quality, Infection Prevention and Control	Commenced on 13/08/2012
Stephanie Watson	Director of Finance and Performance	Seconded to the SHA from 17/09/2012 Left the Trust on 31/03/2013
Mary Leadbeater	Interim Director of Finance and Performance	Commenced on 24/09/2012
Julie Fryatt	Director of Human Resources	
Margaret Blackett	Interim Director of Transformation*	Commenced on 02/07/2012
John Watson	Director of Operations *	Left the Trust on 18/01/2013
Andy Burroughs	Director of Business Development *	Left the Trust on 10/04/2012

* Non-voting board member.

The executive directors work closely with clinicians in developing strategic and operational plans. A senior management team contributes to and implements Board, executive and clinical team decisions.

On 1 April 2013, a new way of leading and managing has been introduced to build a clinically led organisation. There are three divisions each with a Divisional Clinical Director, a Head of Nursing and a Head of Operations, together with clinical delivery groups leads.

For the year covered in this Annual Report, there were seven business units in place with an executive support unit.

Structure and Management

The business units were:

General Acute Services and Pain which included Emergency Department, assessment units, theatres and anaesthetics, critical care and pain management.

General Surgery and Gastroenterology which included gastrointestinal (GI) medicine, colorectal surgery, vascular surgery, upper GI surgery and hepatobiliary surgery.

Specialist and Older People's Medicine which included cardiology, neurology, care of the elderly, respiratory medicine, diabetes, renal medicine, thoracic surgery and dermatology.

Special Surgery which included ENT, ophthalmology, oral surgery, orthodontics, audiology, urology and plastic surgery.

Musculoskeletal Services which included trauma and orthopaedics, and rheumatology.

Women and Children's Services which included maternity services, neonatology, gynae-oncology, sexual health, HIV/AIDS, gynaecology, breast surgery, child health and community midwifery.

Clinical Support Services and Cancer which included diagnostic imaging, pathology, pharmacy, oncology and haematology, therapy services and central outpatients.

Research and Development Strategy

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

Governance

Clinical Governance is about continual improvement in the quality of care provided by NHS organisations, and ensuring that improvements, where needed, are made in a climate which is supportive, open and learning. The hospital has a Risk and Governance Group. Each business unit had a governance group and together they had 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.

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 preparedness and planning.

Listening and learning

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

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

Structure and Management

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

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

Dealt with by the Complaints Team.

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

Dealt with by the Complaints Team.

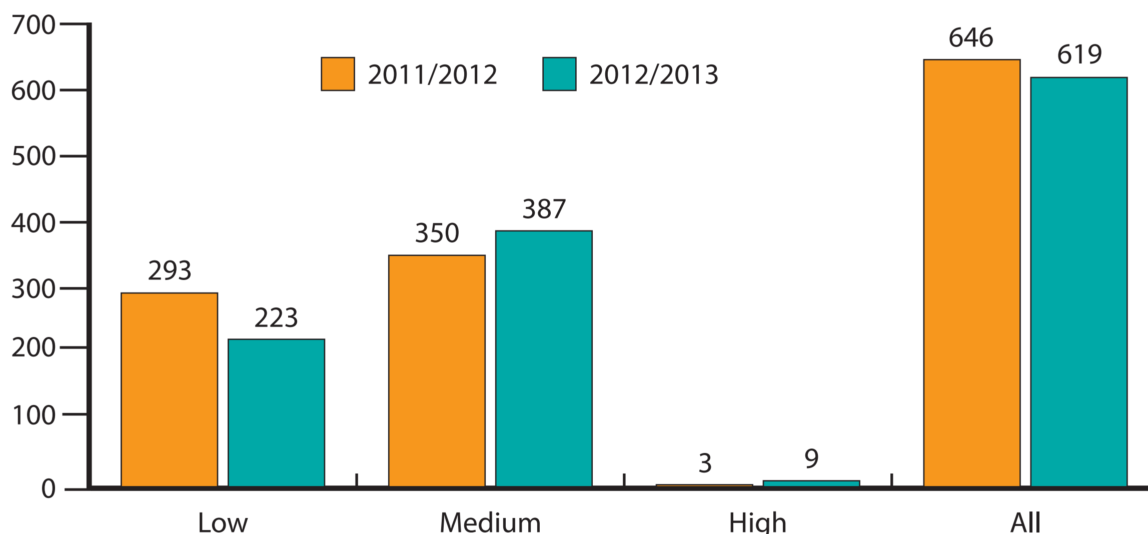
Low level
Simple, non-complex issues including, for example, delayed or cancelled appointments, lack of cleanliness, transport problems.

Dealt with by the Complaints Team or by PALS

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

The number of complaints has dropped slightly compared to the previous year (646 in 2011/12 and 619 in 2012/13). This is very encouraging particularly when taking into consideration the increased level of activity the Trust has experienced.

The PALS service continues to handle queries and concerns in a practical way, resolving and addressing issues at source to prevent issues escalating. This is a really positive step towards taking more responsibility for issues as they arise. The PALS service is now very well established and continues to see an increase in



Structure and Management

demand. There has been a 28% increase in matters raised with PALS from 1,130 in 2011/12 to 1566 in 2012/13.

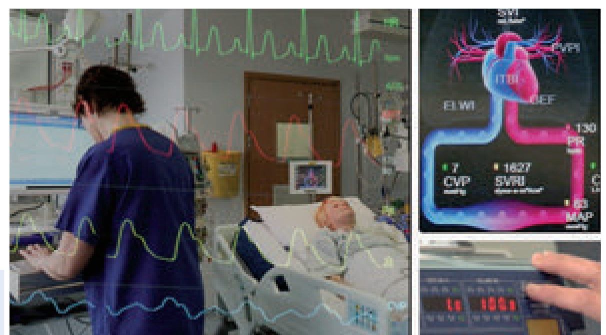
The PALS team attends wards and departments regularly to support staff in handling negative feedback from patients and relatives to encourage local resolution. As mentioned above, our PALS service allows us to monitor issues that may escalate into complaints and any issues are escalated at the time to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

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

If a complainant wishes to take their complaint further we advise them they can contact the Parliamentary and Health Service Ombudsman (PHSO). In 2012/13 11 complaints were taken to the PHSO. Of these, ten were closed by the PHSO without investigation and we are currently awaiting the outcome of the one remaining case.

The PALS and complaints service aim to not only explain and apologise when things go wrong, but work with departments to make constant improvements and adjustments following feedback. Below are some specific examples of actions taken following concerns raised:

- The nursing handover process has now been changed on Lavenham Ward so that patients are more involved in the process, therefore effective communication can be maintained and patients should be fully aware of their care plan.
- Plans are in place for a ward-based midwife to undertake a secondment to the diabetes team in the Antenatal Clinic. This secondment will form a regular rotation to the clinic so that more midwives will be exposed to caring for women with diabetes when pregnant, with the hope that this learning will be shared more widely when the midwives return to the ward environment.
- A more appropriate location/setting is now being sourced for "Teardrop" appointments.
- A deputy general manager has been put in place to help manage the Eye Clinic and ensure that patients get as timely appointments as possible.
- A multiple sclerosis nurse specialist has been put in place for three days a week.



Our Critical Care Unit looks after about 75 patients a month.

Structure and Management

Serious Incidents Requiring Investigation

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

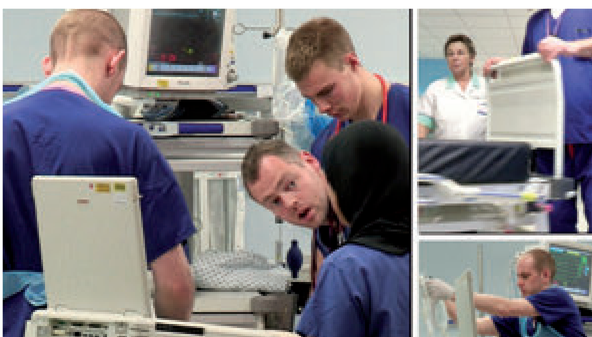
Prompt Payments Code

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

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

Charging for Information

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



The Emergency Department has been awarded Trauma Unit status.

Performance and Accounts

Performance

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

Key facts and figures

Births:
3,790

Emergency Department attendances:
75,127

Planned admissions:
45,438

Unplanned emergency admissions:
29,448

Outpatient attendances:
431,144

Number of appointments people did not attend:
27,407

Diagnostic Imaging examinations:
237,932

Referrals from GPs and dentists:
105,350

Performance

Governance Risk Ratings

Area	Ref	Indicator
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:
	3b	All cancers: 62-day wait for first treatment:
	3c	All cancers: 31-day wait from diagnosis to first treatment
	3d	Cancer: 2-week wait from referral to date first seen, comprising:
	3e	A&E: From arrival to admission/transfer/discharge
Safety	4a	Clostridium difficile
	4b	MRSA
	CQC Registration	
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements

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

Performance

Subsections	Threshold	Weighting	Historic Data: Qtr to Jun 12	Qtr to Sept 12	Qtr to Dec 12	Qtr to Mar 13
Maximum time of 18 weeks	90%	1.0	YES	YES	YES	NO
Maximum time of 18 weeks	95%	1.0	YES	YES	YES	YES
Maximum time of 18 weeks	92%	1.0	YES	YES	YES	YES
	N/A	0.5	NO	YES	YES	YES
Surgery	94%	1.0	YES	YES	YES	YES
Anti-cancer drug treatments	98%					
Radiotherapy	94%					
From urgent GP referral for suspected cancer	85%	1.0	NO	YES	NO	YES
From NHS Cancer Screening Service referral	90%					
	96%	0.5	YES	YES	YES	YES
All urgent referrals	93%	0.5	YES	NO	YES	YES
For symptomatic breast patients (cancer not initially suspected)	93%					
Maximum waiting time of four hours	95%	1.0	YES	NO	NO	NO
Is the Trust below the de minimus	*12*	1.0	YES	NO	NO	NO
Is the Trust below the YTD ceiling	*27*		YES	YES	NO	YES
Is the Trust below the de minimus	*6*	1.0	YES	YES	YES	YES
Is the Trust below the YTD ceiling	*1*		YES	NO	NO	NO
	0	2.0	NO	NO	NO	NO
	0	4.0	NO	NO	NO	NO
	0	2.0	NO	NO	NO	NO
		TOTAL	1.5	2.5	3.0	3.0
			AMBER/ GREEN	AMBER/ RED	AMBER/ RED	AMBER/ RED

Operating Financial Review

2012/13 was a year of transition for Ipswich Hospital, but also the year which saw the start of its transformation into a hospital for the future.

The Trust reported a surplus of £787,000 after meeting all accounting and technical reporting requirements. (This year the Income and Expenditure (I&E) account included net non-recurrent costs associated with transformation and restructuring services of £653,000, non-recurrent costs of £310,000 related to incomplete patient spells, and non-recurrent external government grants and charitable fund income net of depreciation of £582,000). The underlying surplus before recognising the above in year issues was £1,168m.

The delivery of both a reported surplus of £787,000 and an underlying surplus is an important milestone for the Trust and evidences the positive outcome of the actions taken in 2012/13 to respond to issues raised about the Trust's financial resilience.

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

Key target	Requirement	Result	Achieved?
Income and expenditure surplus	Break-even	£787k surplus (£205k adjusted*)	Yes
Capital cost absorption rate	3.5%	3.5%	Yes
External financing limit	Less than £12.9m	£9.4m	Yes
Capital resource limit	Up to £23.0m	£14.5m	Yes

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

The Trust's I&E account included the impact of paying for contractual consequences of £1.8m and a £1m repayment to NHS Suffolk (NHSS) that related to a prior year contractual issue, and the receipt of £2.02m and £653,000 to reflect the impact on higher than baseline contract costs of treating the volume of actual emergency and outpatient attendances. This recognised that the application of national tariffs and NHS 'business rules' meant that despite the rise in emergency activity of 6%, the financial impact to the Trust was effectively an income reduction of £6m.

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

The Trust had received £3.2m from NHSS to implement a robust strategic transformation programme. This included delivering savings of nearly £15m, £3m higher than last year. A number of schemes were part of the transformation programme and included:

- redesign of patient pathways in the Emergency Department ahead of further work to be undertaken in 2013/14;
- improving the discharge process to reduce delays so patients can leave on the day they expect to;
- focussing on clinic and theatre utilisation to minimise waste of expensive clinical resources;
- improving the purchasing of medicines and other hospital supplies;
- introducing new job planning processes for clinical staff; and
- delivering an Estates and Clinical Services Strategy.

Operating Financial Review

Our total income fell by £1.4m and our expenditure by £1.7m, with non-pay costs rising by £3.2m and total pay costs falling by £4.9m, reflecting the reduction in staff numbers of 99 between this year and last year, and over £1.3m saved in agency, bank and locum staff. Supplies and services costs (eg bandages, drugs and medical consumables) fell by over £700,000, despite higher activity, as better procurement was an area targeted by our transformation programme.

We ended the year with £6.7m in our bank account. However our Better Payment Practice Code performance improved with the number of invoices paid within 30 days increasing from 89% to over 93%. We continued to prioritise payments to local businesses paying over 90% by value within 10 days, a major improvement from 63% last year.

The Trust also made its annual £3.3m repayment on its working capital loan with the Department of Health, the final repayment on this loan will be made during 2013/14.

The Trust spent nearly £15m on improving its assets with £4.5m spent on the new Ipswich Heart Centre and over £3.5m on our decontamination service to ensure all our surgical equipment is free of any infection risk. These schemes were funded by the Department of Health. A further £1.8m was invested in improving our maternity areas, £2.0m on new equipment, £1.7m on new information technology and a further £900,000 on other estate improvements.

2012/13 was a year of transition for the hospital, and the first step on our journey to deliver our vision of high quality care in a safe and compassionate environment. This vision has to be based on a strong financial strategy in order to succeed and the medium term financial plans show that with gradually increasing surpluses, the Trust aims to move out a cumulative deficit position before the end of the five-year planning period.

The Trust has shown that the high quality care provided in 2012/13 can be delivered within tight income streams supported by strong budget management and cost control based on the achievement of CIPs. We must also recognise the financial challenge facing all hospitals – how to deliver sustainable seven-day clinical services within an ever tightening financial envelope – a problem that is particularly pressing for hospitals of our size and geography.

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

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

Our Emergency Department treats around 60,000 people a year.

Our Accounts

This summary financial statement does not contain sufficient information to allow as full an understanding of the results of the Trust and of the policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. Where more detailed information is required, a copy of the Trust's last full accounts and reports are available free of charge.

So far as the directors are aware, there is no relevant information of which the Trust's auditors are unaware and the directors have taken all the steps that ought to have been taken to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The summary below summarises the information contained in the Trust's full financial statement for the year ended 31 March 2013, a copy of which can be obtained from:

Paul Scott
Director of Finance and Performance
The Ipswich Hospital NHS Trust
Heath Road
Ipswich
IP4 5PD

The Trust's external auditors are PricewaterhouseCoopers LLP. Audit fees for 2012/13 were £115,000 (2011/12 £174,000).

Independent auditors' statement to the Directors of the Board of The Ipswich Hospital NHS Trust

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Summary Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the related notes, the Directors' Report and the information in the Remuneration Report that is described as having been audited.

We have some of the best radiotherapy treatment machines in the UK.

Our Accounts

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Secretary of State for Health.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the full annual statutory financial statements and the Remuneration Report and its compliance with the relevant requirements of the directions issued by the Secretary of State.

We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statement. The other information comprises only the Chair's Foreword, the Chief Executive's Overview and the Operating Financial Review.

This statement, including the opinion, has been prepared for, and only for, the Board of The Ipswich Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the Trust's full annual statutory financial statements describes the basis of our audit opinion on those financial statements, the Directors' Report and the Directors' Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the full annual statutory financial statements and the Remuneration Report of The Ipswich Hospital NHS Trust for the year ended 31 March 2013 and complies with the relevant requirements of the directions issued by the Secretary of State.

Julian Rickett,
Engagement Lead

For and on behalf of
PricewaterhouseCoopers LLP
Appointed Auditors
The Atrium
St George's Street
Norwich
NR3 1AG

Date: 7 June 2013

Our Accounts

Directors' statement

The auditors have issued unmodified opinions on the full annual financial statements; the part of the directors' remuneration report that is described as having been audited; and on the consistency of the directors' report with those annual financial statements.

The auditors' report on the full annual financial statements contained the following modified conclusion:

The auditors have qualified their value for money conclusion because in their view, in considering the Trust's arrangements for securing financial resilience, they identified that the Trust had not met its 5-year rolling cumulative breakeven target and did not have robust plans in place to:

- achieve approximately £1.2 million of its target savings of £13 million for 2013/14; and
- meet its cumulative breakeven target until 2017.

The auditors' report contained no statement on any of the matters on which they are required, by the Code of Audit Practice, to report by exception.

Our £26 million Garrett Anderson treatment centre is home to Emergency Department, day surgery, an elective surgery ward and Critical Care.

Our Accounts

Statement of Comprehensive Income for the Year Ended 31 March 2013

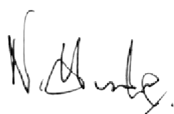
	2012/13 £000	2011/12 £000
Employee benefits	**(139,666)**	(144,531)
Other costs	**(90,233)**	(87,199)
Revenue from patient care activities	**217,407**	213,928
Strategic Transformation Funding	**0**	5,500
Other Operating revenue	**19,325**	18,722
Operating surplus/(deficit)	**6,833**	6,420
Investment revenue	**29**	32
Other gains and (losses)	**(110)**	(3)
Finance costs	**(2,138)**	(2,234)
Surplus/(Deficit) for the financial year	**4,614**	4,215
Public dividend capital dividends payable	**(3,827)**	(3,486)
Retained surplus/(deficit) for the year	**787**	729
Other comprehensive income		
Impairments and reversals	**(1,553)**	(6,099)
Net gain/(loss) on revaluation of property, plant & equipment	**66**	7,842
Total comprehensive income for the year	**(700)**	2,472
Financial performance for the year		
Retained surplus/(deficit) for the year	**787**	729
IFRIC 12 adjustment	**103**	(1,192)
Impairments	**64**	600
Less: Adjustments to donated asset/government grant reserve elimination	**749**	
Adjusted retained surplus/(deficit)	**205**	**137**

Our Accounts

Statement of Financial Position as at 31 March 2013

	31 March 2013 £000	31 March 2012 £000
Non-current assets:		
Property, plant and equipment	**147,424**	141,581
Intangible assets	**4,063**	4,805
Trade and other receivables	**803**	780
Total non-current assets	**152,290**	147,166
Current assets:		
Inventories	**3,772**	3,764
Trade and other receivables	**8,503**	5,881
Cash and cash equivalents	**6,726**	10,330
Total current assets	**19,001**	19,975
Total assets	**171,291**	167,141
Current liabilities:		
Trade and other payables	**(12,765)**	(13,300)
Provisions	**(737)**	(582)
Borrowings	**(1,418)**	(1,398)
Working capital loan from Department	**(3,348)**	(3,342)
Total current liabilities	**(18,268)**	(18,622)
Non-current assets plus/less net current assets/liabilities	**153,023**	148,519
Non-current liabilities:		
Trade and other payables	0	(481)
Provisions	(1,312)	(1,199)
Borrowings	(27,506)	(29,238)
Working capital loan from Department	0	(3,348)
Total non-current liabilities	**(28,818)**	(34,266)
Total Assets Employed:	**124,205**	114,253
FINANCED BY TAXPAYERS' EQUITY:		
Public Dividend Capital	85,185	74,533
Retained earnings	(13,841)	(16,993)
Revaluation reserve	52,861	56,713
Total Taxpayers' Equity	**124,205**	114,253

The summary financial statements on pages 33–37 have been approved by the Board.



Chief Executive
Nick Hulme
Date: 6 June 2013

Our Accounts

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2013

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Total reserves £000
Changes in taxpayers' equity for 2012-13				
Balance at 1 April 2012	74,533	(16,993)	56,713	114,253
Retained surplus/(deficit) for the year		787		787
Net gain/(loss) on revaluation of property, plant, equipment			66	66
Impairments and reversals			(1,553)	(1,553)
Transfers between reserves		2,365	(2,365)	0
New PDC received	10,652			10,652
Net recognised revenue/(expense) for the year	10,652	3,152	(3,852)	9,952
Balance at 31 March 2013	**85,185**	**(13,841)**	**52,861**	**124,205**
Changes in taxpayers' equity for the year ended 31 March 2012				
Balance at 1 April 2011	74,533	(20,987)	58,235	111,781
Retained surplus/(deficit) for the year		729		729
Net gain/(loss) on revaluation of property, plant, equipment			7,842	7,842
Impairments and reversals			(6,099)	(6,099)
Transfers between reserves		3,265	(3,265)	0
Net recognised revenue/(expense) for the year	0	3,994	(1,522)	2,472
Balance at 31 March 2012	**74,533**	**(16,993)**	**56,713**	**114,253**

Our Accounts

Statement of Cash Flows for the Year Ended 31 March 2013

	2012/13 £000	2011/12 £000
Cash flows from operating activities		
Operating surplus/deficit	**6,833**	6,420
Depreciation and amortisation	**8,706**	9,471
Impairments and reversals	**167**	(600)
Donated assets received credited to revenue but non-cash	**0**	(439)
Interest paid	**(2,147)**	(2,219)
Dividend paid	**(3,799)**	(3,398)
(Increase) in inventories	**(8)**	(182)
(Increase)/Decrease in trade and other receivables	**(2,645)**	3,986
Increase/(Decrease) in trade and other payables	**(504)**	(2,450)
Provisions utilised	**(151)**	(2,401)
Increase in provisions	**391**	2,770
Net cash inflow/(outflow) from operating activities	**6,843**	10,958
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	**29**	32
(Payments) for property, plant and equipment	**(16,074)**	(8,503)
(Payments) for intangible assets	**0**	(247)
Net cash inflow/(outflow) from investing activities	**(16,045)**	(8,718)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(9,202)**	2,240
CASH FLOWS FROM FINANCIAL ACTIVITIES		
Public dividend capital received	10,652	0
Loans repaid to DH – Working Capital Loans Repayment of Principal	(3,342)	(3,342)
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT	(1,712)	(1,562)
Capital grants and other capital receipts	0	439
Net cash inflow/(outflow) from financing activities	**(5,598)**	(4,465)
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS	**(3,604)**	(2,225)
Cash and cash equivalents (and bank overdraft) at the beginning of the period	10,330	12,555
Cash and cash equivalents (and bank overdraft) at year end	6,726	10,330

Our Accounts

Better Payment Practice Code

Measure of compliance	2012/13		2011/12	
	Number	**£000**	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	**59,463**	**94,377**	58,924	89,577
Total non-NHS trade invoices paid within target	**53,731**	**81,901**	49,559	72,317
Percentage of non-NHS trade invoices paid within target	93.30%	86.78%	84.11%	80.73%
NHS Payables				
Total NHS trade invoices paid in the year	**1,713**	**9,439**	1,649	11,111
Total NHS trade invoices paid within target	**1,501**	**8,060**	1,366	9,655
Percentage of NHS trade invoices paid within target	87.62%	85.39%	82.84%	86.90%

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

The current year analysis is calculated differently from past year which was based on 34 days.

Remuneration Report

The purpose of the Remuneration Committee is:

- to make appropriate recommendations to the Board on the Trust's remuneration policy and the specific remuneration and terms of service of:
- the Chief Executive;
- the Executive Directors; and
- other staff as determined by the Board.

The objectives of the Committee are to:

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

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

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

All nominated representatives for the quorum must be Non-executive Directors.

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

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

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

Notice periods apply based on the early termination of their contract. The notice periods are as follows:

Chief Executive – six months

Executive directors – three months.

The Trust did not have a bonus scheme in operation during 2012/13.

One executive director who is non-voting, has a performance-related component to their pay, which is determined and overseen by the Remuneration Committee. The performance-related component of this director's pay was agreed by the Remuneration Committee. Performance against each of a range of defined objectives was reviewed and the award ratified by the committee based upon that performance. The employment package was designed at the start to have a variable element.

The Trust made contributions totalling £13.1million needed to the Pensions Agency in the year. Note 10.5 in the Trust's full accounts provides further details as to the nature of the pension scheme and accounting proactive in relation to associated liabilities. Details of the pension benefits of the Trust's senior managers are also given in the Remuneration Report.

Remuneration Report

Salary and Pension Entitlements of Board Members 2012/13	Salary (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Bonus Payments (Bands of £5,000) £000	Benefits in Kind (Rounded to nearest £100) £00
Name and title				
Andrew Reed Chief Executive (01/04/2012 to 18/05/2012)	140–145	0	0	0
Julie Fryatt Director of Human Resources	95–100	0	0	0
Peter Donaldson Trust Medical Director (Tenure ended 31/03/2013)	20–25	140–145	0–5*	0
Stephanie Watson Director of Finance and Performance	125–130	60–65#	0	2
Siobhan Jordan Director of Nursing and Quality (01/04/2012 to 17/06/2012)	20–25	0	0	0
Lynne Wigens Director of Nursing and Quality (13/08/2012 onwards)	60–65	0	0	0
Andy Burroughs Director of Business Development (01/04/2012 to 10/04/2012)	0–5	10–15**	0	0
John Watson Director of Operations (01/04/2012 to 18/01/2013)	80–85	0	0	0
Catherine Morgan Interim Director of Nursing and Quality (18/06/2012 to 12/08/2012)	10–15	0	0	0
Nigel Beverley Interim Chief Executive (21/05/2012 to 31/03/2013) (Paid via Ltd company and includes VAT)	195–200	0	0	0
Margaret Blackett Interim Director of Transformation and Operations (02/07/2012 onwards) (Paid via Ltd company and includes VAT)	170–175	0	0	0
Mary Leadbeater Director of Finance and Performance (24/09/2012 onwards) (Paid through an agency and includes agency fees and VAT)	150–155	0	0	0
Ann Tate Chair (02/04/2012 onwards)	20–25	0	0	2
Dave Norval Non-Executive Director (01/04/2012 to 31/12/2012)	0–5	0	0	0
Julia Holloway Non-Executive Director	5–10	0	0	1
Alan Bateman Non-Executive Director	5–10	0	0	0
Anthony Thompson Non-Executive Director	5–10	0	0	0
Andrew George Non-Executive Director	5–10	0	0	2

*Clinical Excellence Award **Redundancy payment #Mutually Agreed Resignation Scheme (MARS) payment

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

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

Pension Benefits – Board Members 2012/13

Name	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2013 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Andrew Reed	-2.5–0	-5–-2.5	55–60	165–170	1,150	1,082	12	0
Julie Fryatt	0–2.5	N/A	5–10	N/A	87	66	17	0
Peter Donaldson	-2.5–0	-5–-2.5	55–60	170–175	1,325	1,248	11	0
Stephanie Watson	-2.5–0	-2.5–0	35–40	105–110	674	626	15	0
Andy Burroughs	-2.5–0	N/A	0–5	N/A	46	44	-1	0
John Watson	2.5–5	12.5–15	30–35	95–100	521	414	86	0
Siobhan Jordan	-2.5–0	-7.5–-5	15–20	50–55	252	256	-18	0
Lynne Wigens	2.5–5	7.5–10	30–35	100–105	622	525	70	0

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

Remuneration Report

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Median staff pay disclosure

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

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

As one director at the Trust received a termination payment in addition to salary, this meant that the median pay disclosure shows a significant increase in 2012/13. The banded remuneration received by the highest paid director in The Ipswich Hospital NHS Trust in the financial year 2012/13 including this payment was £191,577.38 (2011/12, £139,116.58). This was 6.39 (4.22 excl termination payment) times (2011/12, 4.27) the median remuneration of the workforce, which was £29,991 (2011/12, £32,532). The size of change in this multiplier in 2012/13 was therefore an exceptional change.

In 2012/13, 4 (2011/12, 27) employees received remuneration in excess of the highest paid director. Remuneration ranged from £188,884.87 to £214,103.00 (2011/12, £142,778.10–£213,642.80).

Remuneration Report

Salary and Pension Entitlements of Board Members 2011/12 (Audited)	Salary (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Bonus Payments (Bands of £5,000) £000	Benefits in Kind (Rounded to nearest £100) £00
Name and title				
Andrew Reed Chief Executive	140–145			0
Julie Fryatt Director of Human Resources	95–100			0
Peter Donaldson Trust Medical Director	20–25	140–145	0–5*	0
Stephanie Watson Director of Finance and Performance	125–130			0
Siobhan Jordan Director of Nursing and Quality	90–95			0
Andy Burroughs Director of Business Development	80–85			0
John Watson Director of Operations	95–100			0
Mike Brookes Chair	15–20			6
Dave Norval Non-Executive Director/Acting Chair from 1 January 2012	5–10			1
Julia Holloway Non-Executive Director	5–10			0
Alan Bateman Non-Executive Director	5–10			0
Anthony Thompson Non-Executive Director	5–10			0
Andrew George Non-Executive Director	5–10			1

*Clinical Excellence Award

Pension Benefits – Board Members 2011/12 (Audited)

Name	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2012 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2012 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2012 £000	Cash equivalent transfer value at 31 March 2011 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Andrew Reed	0–2.5	0–2.5	50–55	160–165	1,082	980	70	0
Julie Fryatt	0–2.5	N/A	5–10	N/A	66	38	26	0
Peter Donaldson	2.5–5	12.5–15	55–60	165–170	1,248	1,071	143	0
Stephanie Watson	0–2.5	2.5–5	30–35	100–105	626	539	70	0
Andy Burroughs	0–2.5	N/A	0–5	N/A	44	23	20	0
John Watson	0–2.5	0–2.5	25–30	75–80	414	334	68	0
Siobhan Jordan	0–2.5	2.5–5	15–20	55–60	256	190	60	0

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.

2012/13 Governance Statement

Scope of responsibility

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

The governance framework of the organisation

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

The Trust Board is comprised of a Chair, five Non-executive Director members and five Executive Director members with one other executive director member without voting rights attending each meeting: the Interim Director of Transformation. The Chair has a second and casting vote. The Trust Secretary also attends all Board meetings. The Chair commenced a four-year tenure on 2 April 2012 following appointment through the Appointments Commission process. In addition, the Deputy Chair decided to step down at the end of December 2012 because their second term of office was due to end in October 2013 and they wanted to enable a new Non-executive Director to be appointed who would be able to remain with the Trust for the entire process to Foundation Trust Status. A new Non-executive Director was appointed through the Appointments Commission process and commenced their four-year tenure on 1 April 2013. A new Deputy Chair was appointed from the existing Non-executive Directors.

There has been substantial change in the executive team during the year with five of the six executive directors having changed. The Chief Executive left the Trust in May 2012 and an Interim Chief Executive (acting as Accountable Officer) was appointed in May 2012 for a period of up to one year. A substantive Chief Executive was recruited and

2012/13 Governance Statement

commenced employment on 1 April 2013. The Director of Nursing and Quality left the Trust in June 2012 with the post being covered internally until August 2012 by the Associate Director of Nursing when a new substantive Director of Nursing and Quality commenced employment. The Director of Finance and Performance left the Trust in September 2012 and an Interim Director of Finance and Performance was appointed in the same month. A substantive Director of Finance and Performance was recruited and commenced employment on 3 June 2013. The Medical Director's term of office came to an end in March 2013 and a new Medical Director appointed from within the organisation commenced in role at the beginning of April 2013. The Director of Operations left the Trust in January 2013 to take up a career opportunity at another Trust and the Interim Director of Transformation covered the role in the interim. A decision was made to establish the role of Chief Operating Officer and an appointment was made with a commencement date of July 2013.

The Board undertook a review of its meeting practice during the year and from October 2012 moved from holding a Board meeting in public bi-monthly to monthly, with the first part of each meeting open to the public and closing as necessary for a part two confidential session. Both sections of the meeting follow a structured format with each public meeting starting with a patient or carer story to set the tone and focus of the meeting. The patient/carer story is followed by matters of strategy, performance and corporate governance. The Board has also held a number of additional meetings during the year when business has necessitated this and the Board is mid-cycle: specifically meetings have been held on the Annual Plan and Trust Strategy and the Transforming Pathology Partnership.

In addition the Board holds seminar sessions which provide an opportunity for the Board to be briefed on a number of issues of interest or to focus on in-depth work required for strategic matters. During the year the Board has covered the following topics in its seminar sessions: The Health Act 2012, Care of Older People Strategy, Local Education Training Boards, Quality Governance Framework, Board Governance Assurance Framework, Trust Strategy, Long Term Financial Model and Cost Improvement Plans. All Board members are actively encouraged to suggest topics for the seminar sessions.

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

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

The Audit, Healthcare Governance and Finance and Performance Committees are the main assurance committees reporting to the Board. During the year, the Chair undertook a review of Non-executive Director membership of committees and as a result changes were made to the allocation of committee membership. The major change was that the Audit and Healthcare Governance Committees moved from having all five Non-executive Directors as members to having three Non-executive Director members each.

The Audit Committee supports the Board by providing an independent and objective review of the governance and assurance processes upon which the Board places reliance. In this capacity as independent reviewer of the internal control environment the Audit Committee is the scrutiniser of all committees including the Healthcare Governance Committee. The Audit Committee membership comprises three Non-executive Directors and is chaired by a Non-executive Director. The Chief Executive, Interim Director of Finance and Performance, Trust Secretary, Head of Internal Audit and a representative from the external auditors attend the Audit Committee meetings. Officers of the Trust are invited to attend the Audit Committee to report on standing items such as the review of the Board Assurance Framework (BAF) and also as requested on exceptional items.

The Healthcare Governance Committee oversees the

2012/13 Governance Statement

development of risk and clinical governance activities and ensures their effective management in order to improve the quality of care throughout the hospital. The Committee has a number of reporting committees and provides assurance to the Trust Board on all matters relating to quality including patient safety, clinical effectiveness and patient experience and engagement. It focuses on overseeing the development of risk management activities through the Risk Management Committee.

The Healthcare Governance Committee receives assurance on the quality agenda and clinical governance activities through the Patient Safety and Clinical Effectiveness and Patient Experience Groups which report into it. The Healthcare Governance Committee is chaired by a Non-executive Director, and two other Non-executive Directors are members of the committee together with a number of the executive directors including the Director of Nursing and Quality, the Medical Director and the Interim Director of Transformation. The Trust Secretary attends the Healthcare Governance Committee meetings. The Head of Internal Audit also attends to mirror their attendance at the Audit Committee. The Audit Committee and Healthcare Governance Committees receive each other's minutes to ensure that there is no overlap or inadvertent omission. The Board receives a highlight report and unconfirmed minutes of both the Audit Committee and Healthcare Governance Committee at its next meeting following the committee meetings. Any amendments subsequently made to the minutes at their confirmation are reported to the next Board Meeting. The Board may request further work on various issues which are raised.

During the first two quarters of the year the Finance and Performance Committee operated as an executive-led Committee chaired by the Chief Executive with membership comprising the Executive Directors and Clinical Directors of the Trust. At the end of September 2012 the Committee was reconstituted as a Non-executive Director-led committee chaired by a Non-executive Director and with membership comprising two other Non-executive Directors, the Chief Executive, Interim Director of Finance and Performance, Director of Operations, Director of Nursing and Quality, Director of Human Resources and Trust Secretary.

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

Both the Audit and Healthcare Governance Committees submit an annual report to the Board to review the work undertaken during the year and to set out how they have performed against their responsibilities as defined in their terms of reference. In addition both committees undertake an annual self assessment which informs the annual report. The Audit Committee's self assessment results are discussed at the June Audit Committee meeting and the Healthcare Governance Committee self assessment results are discussed at the May committee meeting.

The Remuneration and Terms of Service Committee is chaired by the Chair of the Trust Board and the five Non-executive Directors of the Trust are members. The Chief Executive and Director of Human Resources regularly attend meetings. The committee makes appropriate recommendations to the Board of Directors on the Trust's remuneration policy and the specific remuneration and terms of service of the Chief Executive, Executive Directors, Senior Management and employees employed under Ipswich Hospital's terms and conditions of service, together with other employees as determined by the Board of Directors.

The Ipswich Hospital NHS Trust is the corporate trustee for charitable funds held on trust and the Trust Board serves as its agent and has delegated authority to the Charitable Funds and Sponsorship Committee to make and monitor arrangements for the control and management of the Trust's Charitable Funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission. The Committee is chaired by a Non-executive Director

2012/13 Governance Statement

and membership comprises a further Non-executive Director, the Interim Director of Finance and Performance, Director of Nursing and Quality, Nominated Fund Manager, Patient Group Representative and Head of Communications.

The Trust Board met as corporate trustee to approve the Ipswich Hospital charitable funds annual report and accounts for the year ended 31 March 2012, to approve the Letter of Representation and to receive the ISA2260 Report from the external auditors.

The Conflicts of Interest Committee was established to evaluate, monitor and supervise real and potential conflicts of interest to ensure compliance with legislation and Trust policies. This is done by working with employees to eliminate, minimise and manage any actual or potential conflicts of interest to protect the reputation and tangible assets of the Trust as well as the reputation of individual employees.

The Board has Standing Orders, a Schedule of Matters Reserved to the Board, Standing Financial Instructions and a Scheme of Delegation which were reviewed twice in 2012/2013: at the beginning of the year and at the end of the year in advance of the introduction of the new organisation structure. The Trust undertook a review of the organisation in 2012 /2013 to develop a clinically led organisation. The overarching intention was to create a single line of accountability for all aspects of performance including patient safety, patient experience, operational standards, financial performance and staff engagement. Importantly the introduction of the new structure sought to secure the engagement of clinicians including doctors, nurses, midwives and allied healthcare professionals in the leadership of the hospital. As a result, a number of changes were made to the existing governance arrangements.

Following consultation a revised structure became operational from 1 April 2013 which comprised three clinical divisions which better reflect how patients come into hospital: Medicine and Therapies; Surgery; Cancer, Women and Children, and which are supported by an executive function. Each Division comprises a number of clinical sub-groups called Clinical Delivery Groups. Whilst the restructure did not significantly affect the composition or remit of the Board's assurance committees, it did result in changes to the operational management of the hospital with the cessation of the Trust Management Team and the creation of three Divisional Boards and a Combined Board which follow a four-weekly meeting structure as follows:

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

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

Formal evaluation of the Board during its public and confidential board meeting was undertaken in September 2012 by the Strategic Health Authority as part of the Trust's Foundation Trust application process. There were no significant issues arising through this observation process and following the feedback received a review of Board practice was undertaken by the Trust Secretary and a number of proposals

2012/13 Governance Statement

made which were considered by the Board in November 2012. A progress report on the changes was received by the Board in February 2013. The Board undertook an initial assessment against the Board Governance Assurance Framework in October 2012 and identified the requirement for a formal evaluation of the Board and subsequent establishment of a board development programme. Due to the number of interim directors and the changes at board level the formal evaluation has not yet been undertaken and it is planned that this will be undertaken once the new Board has begun to embed.

The Care Quality Commission made an unannounced visit to the Trust on 26 July 2012 as part of their planned routine of scheduled reviews. The inspection team focused on the following outcomes:

- privacy and dignity;
- care and welfare of people who use our services;
- nutrition;
- cleanliness and infection control;
- supporting workers; and
- quality.

The CQC determined that the Trust was compliant with all outcomes inspected.

The risk and control framework

Risk assessment

As Chief Executive, I have overall responsibility and accountability for risk management and this is shared with Executive Directors, who along with the whole of the Trust Board are informed on risk management and governance issues through the Healthcare Governance Committee, Audit Committee, and Finance and Performance Committee.

The Trust uses the National Patient Safety Agency 5X5 risk matrix to assess the likelihood and consequence of all risks on the Trust Risk Register (see Table 1).

Risks scoring 15 and above (strategic) migrate to the Board Assurance Framework and thereby inform the Trust Board agenda. The following risks were identified and added to the Board Assurance Framework in 2012/13:

- Failure to deliver the planned financial plan for 2012/13 and financial duties.
- Successful Foundation Trust application.
- Financial risk of Strategic Health Authority delay in awarding community contract to Transforming Pathology Partnership.
- Failure to meet 18-week RTT Service Standard for Trauma and Orthopaedics.

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

The Director of Nursing and Quality is the Executive Director with delegated responsibility for the coordination, implementation and evaluation of risk management systems Trust wide.

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

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

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

- **Identification and reporting of risk** – Identification of the risks facing the Trust, working in a way that spreads the workload and ensures that the initial identification of risk is not too onerous;

2012/13 Governance Statement

Table 1:
5X5 Risk Matrix

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

- **Calculation of the importance of each identified risk** – Achieved by undertaking an assessment of the 'likelihood' of the risk occurring and determining the 'consequences' should the event occur, using a matrix based on the National Patient Safety Agency risk matrix;
- **Confirmation or introduction of controls and mitigating actions** – This stage of the cycle aims to confirm or introduce specific controls to deter and prevent the materialisation of identified risks. These controls (eg policies and procedures, controls and reporting mechanisms, deterrent and disciplinary actions) will differ and be prioritised according to the severity of the risk involved;
- **Assessment of the level of residual risk** – This is the assessment of the effectiveness of the controls that are already in place and revised ones that are being implemented following the identification of a perceived risk; and
- **Review and challenge** – The Trust monitors and reviews all reported risks, using the same methodology as outlined above to ensure that controls remain effective and robust.

A register of identified risks facing the Trust is in place. This details risk issues, severity of risk, controls in place and agreed action plans. It has been developed by the identification and assessment of risks at a local level within the Trust. All principal risks are subject to a continuous process of review and validation by Divisions (business units until end of March 2013), and the Trust's Risk Management Committee. The Healthcare Governance Committee and Combined Divisional Board (Trust Management Team up until end of March 2013), are informed of all principal (extreme) risks on a bi-monthly and monthly basis respectively, or earlier if deemed necessary. In addition, during the year a piece of work has been undertaken to align risks to the three assurance committees via the NPSA domains and to the Trust's strategic objectives. Dashboards are being developed to enable the assurance committees to monitor their risks. The Trust formally investigates all serious clinical incidents (Serious Incidents Requiring Investigation – SIRIs), reports their findings via the Risk Management Committee and follows up on all actions agreed as part of the outcome of the report.

The Directors of the Trust are required to satisfy themselves that the Trust's annual Quality Account presents a balanced picture of the Trust's performance over the period covered and the performance information reported in the Quality Account is reliable and accurate. In doing so, we are required to put in place a system of internal controls over the collection and reporting of information included in the Quality Account. The Board has been actively involved in the preparation of the Trust's annual Quality Account and the proposed improvement priorities for the coming year. The Trust has consulted widely on its quality priorities with internal and external stakeholders, who have an opportunity to comment on the programme.

2012/13 Governance Statement

Data security

In 2012/2013 the Trust achieved a satisfactory assessment at 82% for its information governance assurance under the Information Governance Toolkit.

The Trust had two data security breaches that were reported to the Information Commissioner's Office during 2012 /2013. Both breaches related to paper-based data loss. They were:

In April 2012 the Trust identified a level 4 information governance breach which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 12 April 2012 (ICO reference number: ENF0444086). A summary sheet with details of five patients was removed from a patient's bedside table. A patient's relative picked up the summary sheet and removed it from the ward. The details of the five patients included medical summary, name, date of birth, next of kin and care summary. The record was returned by the patient's relative.

In December 2012 the Trust identified a level 3 data breach which was reported as a Serious Incident Requiring Investigation and reported to the Information Commissioner's Office on 11 December 2012 (ICO reference number ENF0477072). A patient attended Washbrook Ward and brought with their appointment letter another piece of paper that was attached to the appointment letter. The attached piece of paper was a theatre list for ODCU (Ophthalmic Day Care Unit) for a specific date in November 2012. The theatre list contained details of four patients including names, date of birth, hospital number and procedure.

Actions taken to mitigate future incidents include all information security incidents being graded and reported according to the Trust's Serious Incidents Requiring Investigation Policy. This enables learning to result from any incidents. In addition mandatory annual training and education of staff for information governance is undertaken. The Trust's Information Management and Technology strategy is focused on a paper-light organisation and includes the use of Lorenzo Regional Care, Evolve Mobile, scan-on-demand medical records service and managed print services. The Chief Information Officer has attended the Audit Committee to provide an overview of information and information technology assurance.

Performance against national priorities set out in the NHS Operating Framework 2012/2013

During 2012/2013 the Trust has demonstrated good performance against the key performance indicators. Key achievements this year include:

- Full year compliance at 95.35% across 2012/13 with the 95% threshold for Accident & Emergency 4-Hour waits.
- Compliance across both the 18-Week admitted and non-admitted thresholds across the 2012/13 reporting year.
- Compliance across the 2-Week, 31-Day and 62-Day Cancer Treatment targets across 2012/13 as a reporting year.
- The Trust also achieved its C.difficile trajectory for no more than 27 cases in 2012/13.

The Trust did not achieve its MRSA trajectory of no more than one case in year, recording two cases across 2012/13. The Trust also failed to achieve the 99% compliance required on diagnostic tests undertaken within six weeks due to problems across the first six months of 2012/13 achieving 98.34%.

2012/13 Governance Statement

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. His opinion is that the overall arrangements provide good assurance. However, only limited assurance could be provided on the controls in certain areas including consultant job plans and car park income. In addition to the Head of Internal Audit opinion, the Audit Committee Chair provides the minutes together with a brief summary highlighting areas for the Board's attention following each committee meeting to the next Board Meeting in public.

During the year the Trust also took positive steps to ensure audit recommendations were also closed down in a timely manner. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by comments in reports and other feedback from Internal Audit, External Audit, NHS Litigation Authority for NHS Trusts, NHS Litigation Authority for Maternity Services and internal Trust updates on progress against the action plans from various internal and external reviews of internal control and the core standards self assessment declaration. I also take into consideration reviews by other external bodies including the Ipswich Hospital Users Group, Suffolk County Council Overview and Scrutiny Committee, Midlands and East of England Strategic Health Authority and Department of Health.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Trust Management Team, Audit Committee, Healthcare Governance Committee and Risk Management Committee as part of our approach to integrated governance. In summary, the Board reviews the BAF and receives minutes and brief highlight summaries from both the Audit Committee and Healthcare Governance Committee. The Audit Committee reviews the underlying assurance processes and the effectiveness of the management of strategic risks. A key role of the Healthcare Governance Committee is to review action plans to mitigate risks identified. It is assisted in this role by the Risk Management Committee which identifies operational risks and ensures that local controls are in place to manage these. The Executive Directors have the key role in managing risks, monitoring the control environment and ensuring that a BAF is produced for Board review. The internal auditors provide independent assurance on the application of governance, internal control and risk management. The external auditors provide independent assurance in respect of statutory accounts and value for money.

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

The external auditors have issued an unqualified opinion on the annual financial statements and a modified value for money conclusion. The qualified conclusion is by exception and relates to securing financial resilience and economy, efficiency and effectiveness. There were two reasons for this conclusion. In respect to the 2013/14 cost improvement plans (CIP) – at the time of the audit, CIP schemes had been identified for 2013/14 to the level of £11.6m/90%. These had been identified and financially risk rated, leaving £1.2m still to be identified, costed and quality assured. In addition, the Trust has not met its statutory target to break even over a five-year period, with a cumulative deficit remaining of £3.4m.

During 2012 the Hospital completed actions to the satisfaction of the Royal College of Surgeons and NHS Suffolk addressing issues raised as a result of a Royal College of Surgeons invited review of colorectal surgery at the hospital in September 2011 in response to concerns raised by individuals relating to safety, effectiveness and experience in the colorectal surgical service. The main issues addressed included referral pathways from Primary Care, the appointment of a nurse specialist to support patients, review of arrangements for analysis of pathology specimens, organisation, support and attendance of multidisciplinary teams, additional colorectal surgeon post agreed, and review and revision of arrangements

2012/13 Governance Statement

for the management of patients with liver metastases.

During 2012 the Hospital received a final report of an investigation undertaken independently into contractual arrangements entered into by the Trust with an external healthcare provider in 2010/11 and 2011/12. The final report confirmed that the Hospital's standing financial instructions had been breached. Work was then completed during 2012/13 to address issues raised in the final report including a review and re-launch of the standing financial instructions and scheme of delegation and a review of the Trust's Standards of Business Conduct.

In April 2012, NHS Suffolk undertook a quality review of the Hospital, making a number of recommendations. The main issues addressed included: strengthening of clinical engagement within the organisation; increased awareness of day-to-day working and front-line staff views by Board members; robust and planned approach to escalation bed increases and reporting on the impact of escalation bed activity decisions to Trust Board; review of nurse staffing and agreement from the Board to increase nurse staffing levels; implementation of e-rostering; and a comprehensive review of non-nursing staffing requirements, including medical staffing, undertaken. The progress of the resulting Quality Review action plan was regularly monitored by the Healthcare Governance Committee, and regular feedback on progress was given to the Commissioners. The Trust confirmed and the Commissioners agreed that all actions were completed in March 2013.

Regrettably one Never Event occurred at the hospital in 2012/13. Never Events are adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable if the available measures have been implemented by healthcare. An investigation took place following this incident and areas where improvement could be made were identified and implemented. The changes implemented are regularly audited to ensure they are sustained and become embedded.

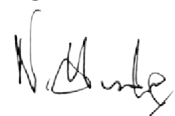
In March 2013 the Midlands and East Multiprofessional Deanery undertook a performance and quality assurance visit to the Trust as part of a scheduled two-yearly cycle. The decision of the Deanery in relation to medical education and training had been met with conditions. The conditions related to patient safety issues in the Emergency Department and their relationship to training, supervision and support for Foundation trainees at night in Medicines and Surgery. The Trust has established an action plan in response to the findings which was reviewed at the Trust Board in April 2013. Confirmation of completion of actions on immediate concerns has been sent to the Deanery with a formal update to the Deanery due by 6 September 2013. In addition, an interim follow-up meeting with the Deanery is scheduled for 18 July 2013. Completion of the action plan is being monitored through the Healthcare Governance Committee.

An internal audit report on the quality of consultant job plan (weekly diary plans) records resulted in limited assurance and a number of recommendations including one high priority recommendation that the job planning process for 2012/13 should have been fully completed by December 2012. In reviewing the job planning process it became clear that the proposed dates were not consistent with the scale of review, capacity planned approach and team job plan approach. The medical staffing steering group will set revised timescales to complete job planning, in conjunction with clinical leaders. Job planning guidance has been drafted. A detailed action plan will be overseen by the medical staffing steering group and reported to the Combined Board.

Accountable Officer:
Nick Hulme

Organisation:
The Ipswich Hospital NHS Trust

Signature:



Date:
06 June 2013

Declaration of Interests

Declaration of Interests 1 April 2012 to 31 March 2013	
Ann Tate Chair (From 02/04/2012)	• Governor of Rattlesden CEVC Primary School
Alan Bateman Non-executive Director	• Paid Employee/Director/Substantial financial interest in Sailotone Ltd
Andrew George Non-executive Director	• Director of Suffolk Mind • Standards Committee Member for Suffolk Councils
Julia Holloway Non-executive Director	• Employee of Geoff Holloway, Independent Financial Advisor • Trustee – Age UK Suffolk
Dave Norval Non-executive Director (Until 31/12/2012)	• Paid Employee/Director/Substantial financial interest in URSA Limited Co No 4197496 • Paid Employee/Director/Substantial financial interest in Team Business Ltd Co No 6269715 • Director/Substantial financial interest in URSA Ghana Limited • Chairman – Ipswich Beira Health Initiative
Tony Thompson Non-executive Director	• Paid employee in Parasol Ltd • Trustee for the Melton Trust • Elected councillor Melton Parish Council
Andrew Reed Chief Executive (Until 18/05/2012)	• Governor of Little Bealings School • Married to Dr PJ Newman, salaried GP, Barrack Lane Medical Centre, Ipswich, and Consultant in Public Health, NHS Suffolk (currently seconded to NHS Midlands and East)
Nigel Beverley Interim Chief Executive (From 21/05/2012)	• Paid employee of NB Health Consulting Ltd • Non-executive Director of Fortrus Ltd from 01/02/2013 • Married to Ruth May, Chief Nurse for NHS Midlands and East
Margaret Blackett Interim Director of Transformation (From 02/07/2012)	• Paid employee/partner in Blackett Sharp Ltd • Director of Britannia Sailing School Ltd
Peter Donaldson Medical Director (Until 31/03/2013)	• Partner in Ipswich Urology Partnership until 31/10/2012 • Married to Rosemary Donaldson, Matron/Senior Manager at Ipswich Nuffield Hospital
Julie Fryatt Director of Human Resources	• Motor home rental business trading under the name Sunrise Motor Homes
Stephanie Watson Director of Finance and Performance (Seconded to SHA 17/09/2012. Left Trust 31/03/2013)	• Office holder Friends of Withersfield • Office holder PCC St Marys Withersfield • Office holder Village Hall Management Committee Withersfield
Mary Leadbeater Interim Director of Finance and Performance (From 24/09/2012)	• Director of Esther Troy Ltd • Trustee of Asthma UK • Member of Asthma UK Finance and Audit Committee • Director of the Caxton Foundation • Chair of the Caxton Foundation Audit Committee
Siobhan Jordan Director of Nursing and Quality/ Director of Infection Prevention and Control (Until 17/06/2012)	• Nil

Continued overleaf...

Declaration of Interests

Continued from previous page

Catherine Morgan Interim Director of Nursing and Quality/ Director of Infection Prevention and Control (From 18/06/2012 until 12/08/2012)	• Nil
Lynne Wigens Director of Nursing and Quality/ Director of Infection Prevention and Control (From 13/08/2012)	• Visiting Senior Fellow – University Campus Suffolk
Andy Burroughs Director of Business Development (Until 10/04/2012)	• Nil
John Watson Director of Operations (Until 18/01/2013)	• Nil

Glossary of Terms

Glossary of Terms	
The Ipswich Hospital NHS Trust	• Referred to as ‘the Trust’, ‘the hospital’ or ‘we’ throughout this report.
NHS Suffolk	• The Primary Care Trust for Suffolk
NHS	• National Health Service
GP	• General Practitioner
DH	• Department of Health

Thank You To...

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

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

In 2012, local film-maker Nick Wainwright gave his services free of charge to make a video that showcases just some of the people and places that make up our Trust. We have used images from his film throughout this report. You can watch the whole film at www.ipswichhospital.nhs.uk/aboutourhospital or, if you are viewing this document as a PDF, simply click the image on the left to watch it via YouTube.

Find out more about the hospital by visiting our website at www.ipswichhospital.nhs.uk

Further copies of this report are available from:
The Press Office (N057)
The Ipswich Hospital NHS Trust
Heath Road
Ipswich
Suffolk
IP4 5PD

Tel: 01473 704770
Email: press.office@ipswichhospital.nhs.uk

This Trust is working towards equal opportunities.

Published: Summer 2013

DPS Ref: 02181-13 © The Ipswich Hospital NHS Trust, 2013. All rights reserved. Not to be reproduced in whole, or in part, without the permission of the copyright owner.