

Annual Report and Accounts 2011/12



Our Passion, Your Care.

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This Annual Report has been prepared in accordance with the requirements set out in the 2011/2012 NHS Trust Manual for Accounts.

Welcome

Chief Executive's Overview



Andrew Reed,
Chief Executive.

The year covered in this Annual Report 2011/12 proved an exceptionally challenging one for the Trust. This was caused initially by having the consequences of an unannounced Care Quality Commission (CQC) inspection into standards of dignity and nutrition for older people, and then in managing a loss of financial control that resulted in the Trust withdrawing from the final stage of the Foundation Trust assessment process. During the course of the year, however, the Trust was successful in meeting the key national operational standards and maintaining its record for patient safety improvement.

The CQC made its inspection in March 2011 as part of a national programme of visits, and the report was published in May 2011. The results were poor – with moderate concerns and compliance actions in each of the areas – but the Trust was arguably unlucky to face adverse media attention at a national level as a result of being featured in the first wave of announced results. Although expected within three months of the original inspection the follow-up did not take place until the end of September, but the Trust received an excellent report on dignity, nutrition and eight other CQC standards which cleared both moderate concerns as well as a number of minor concerns. One new moderate concern was raised related to the need for further work in contractual developments between the Trust and commissioners to ensure people using services can be

confident that the care, treatment and support provided to meet their assessed needs is robust and all those involved co-operate to ensure this happens. This work is ongoing in partnership with NHS Suffolk and Norfolk and Suffolk NHS Foundation Trust.

The Trust started the year with a financial plan to achieve a £2.1m surplus but a high level of unplanned costs coupled with the failure to achieve planned levels of income meant that by the end of July it was over £7m adrift of its target. Immediate recovery actions were put in place, with a plan subsequently agreed with NHS Suffolk and NHS Midlands & East to achieve breakeven at year end through £11.7m of cost reductions in the second half of the year and a package of one-off financial support. The Trust in fact achieved a small surplus at year end, although further support was received to cover a shortfall associated with additional nursing

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 krótkie 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 traduzido 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 বনুন।

Kurdish كورد

ئگەر دەتەنەوێت کورتەبەیک یان هەمووی نەم بەلگەبەتەن بە ئێماننیک تێر هەبێت، تکایە لە یەکێک لە هاوڕێکانی خۆتان کە بە ئێمانی نینگلیزی قسە دەکات داوا بکەن بە ژمارە تەلەفۆنی 01473 704770 پەیوەندیمان بێوێه بکات.

Farsi فارس

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

The Quality Account 2011/12 is a companion document to this report and is available on line at www.ipswichhospital.nhs.uk

Chief Executive's Overview

costs to manage a difficult winter and the need to maintain emergency department services.

With significant one-off support in-year, the Trust did not achieve the financial management requirement for a successful FT application, and the board chose to withdraw its application, breaching its Tripartite Formal Agreement with the Department of Health and SHA.

On a more positive note, the Trust continued to maintain its excellent record of infection control, making further significant reductions in rates of C.diff (bringing the average down to around two a month) and having no MRSA blood-borne infections for the last ten months of the year. Mortality rates have also remained below the national and regional averages, and the Trust has maintained waiting times within national standards for cancer, routine and A&E waits.

The hospital had a major boost with the announcement in early spring this year of £10m funding from the Department of Health to build an invasive cardiology centre and a new sterilisation centre on site. Both will be up and running by autumn 2013.

The Quality Account 2011/12 is a companion document to this Report and I would encourage you to read it for more information about the hospital's work on improving quality of

treatment and care and involving patients more closely in designing and running services.

I began this overview with a focus on the challenges we have faced. I'd like to conclude by expressing my gratitude to all of our community for their continued fantastic backing. I would particularly like to thank all of our members of staff, our brilliant army of volunteers, fund-raisers, supporters and members for the difference they make to the hospital.

I would also like to applaud the work of Mike Brookes, Chairman of the Trust, who retired at the end of December 2011 after a five-year term of office, and thank Dave Norval who became Interim Chair from January until 31 March 2012. We welcome Ann Tate CBE our new Chair who took up her appointment on 2 April 2012.

With best regards,



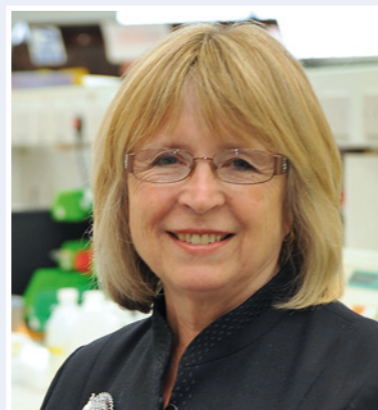
Andrew Reed
Chief Executive
31 March 2012



Mike Brookes,
Former Chairman.



Dave Norval,
Interim Chairman.



Ann Tate CBE,
Trust Chair from 2 April 2012.

Chief Executive's Overview

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, needs, 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 communication. We welcome feedback, learn from our mistakes and build on our successes.

Compassion

We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.

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.

What We Need To Tell You

Background and Context

Background and Context



Jan Wright,
Matron, Trauma and Orthopaedics.

The Ipswich Hospital NHS Trust is a National Health Service Trust providing hospital-based healthcare to more than 356,000 people who live in and around Ipswich and east Suffolk. The Secretary of State for Health approved Trust status for The Ipswich Hospital in April 1993.

The hospital is geographically located in the Suffolk county town of Ipswich, the fastest growing urban centre in East Anglia, and administratively within the boundaries of NHS Suffolk (Primary Care Trust), Suffolk County Council and NHS Midlands and East (the strategic health authority).

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 and cancer surgery to a wider population, as well as outreach services in a number of clinical specialties.

It is a safe hospital, with low standardised mortality rates. The hospital has 510 beds (as of 31 March 2012) in general acute, maternity, paediatric and neonatal services and had an annual turnover of £234 million in 2011/12. Across its 46-acre site, the Trust employs just over 3,000 whole time equivalent NHS staff.

The Trust offers a comprehensive range of acute and secondary care patient services:

- Full Emergency Department; Emergency assessment and treatment services; Elective (planned) surgery and medical treatments; Critical Care Unit; a wide range of outpatient services; Maternity services; Paediatric (children's) services; Diagnostic services; a wide range of therapy services; Chemotherapy and radiotherapy services;
- A range of more specialist services including vascular surgery (joint rota with Colchester Hospital University NHS Foundation Trust (CHUFT)), spinal surgery, gynae-oncology (networked with Colchester (CHUFT) and Mid-Essex), bone marrow transplantation (networked with Cambridge University Hospitals), and high level (level 2) neonatal intensive care.

Strategic Objectives

The hospital's mission is to be renowned for its commitment to excellence in the provision of healthcare, with an emphasis on safe, reliable personal and responsive emergency care, planned care, maternity and children's care; nationally recognized care for older people in hospital; and providing a number of more specialised services where they meet defined accreditation standards.

The overall aim of the hospital is captured in the strap line 'our passion, your care', and it is underpinned by three strategic objectives which are to provide:

- Safe, reliable, personal and responsive emergency care, planned care, maternity and children's care

These are our local acute services, the principal services that the hospital offers to its population and represent the vast majority of what we do. We want our patients to have a superb experience, in terms of outcome, safety and overall "customer" experience.

These local acute services will be supported by fast and effective diagnostics and driven by the principles of "right first time" and "no delays". As a result, we expect people to stay in hospital for no more than two weeks at most, and many to stay for four-to-five days or fewer.

- Nationally recognised care for older people in hospital

Around two-thirds of our core catchment population live in rural east Suffolk, which has one of the fastest growth rates of very elderly people (over 80s) in the country. We want the hospital to be among the very best for the experience that older people have in hospital.

- A number of more specialised services where they meet defined accreditation standards

We have developed over time a number of more specialised services that are not typically provided in local acute hospitals. In keeping with our mission to be committed to excellence, we will work with the East of England Specialised Commissioning Group and NHS Suffolk to provide a range of specialised services where we can demonstrate excellence that conforms to national standards of accreditation as a minimum. Some of these services we already provide, but we also believe there will be opportunities to develop new and additional services.

What we want to achieve:

Over the coming years we intend to deliver:

- standards of quality and safety for patients that are consistently rated as excellent;
- quick and convenient access to our services;
- an empowered, innovative and accountable workforce;
- responsible, accountable and effective financial management; and
- strong partnership with the rest of the NHS, local authorities and our community at large.

Looking to the future:

The Trust's overarching business strategy is one of consolidation. We recognise the need to change the way we deliver our services; we expect some services to experience an increase in activity whilst other services will experience a decrease in response to market changes.

The Trust's strategy is to develop our services and maintain our position in the area for providing acute and specialised services to the wider community. We will also deliver, where appropriate, more services in community-based settings.

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

Background and Context



Cath Gorman,
Associate Director of Nursing –
Quality & Compliance.

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:

- The prevention of pressure ulcers which develop in hospital
- For every patient to have a clear management plan with regular senior review
- Looking after patients with dementia – implementing a dementia strategy
- Making improvements in main complaint areas – communication and attitude.

The Quality Report 2011/12 is available from late June 2012.

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. We received unqualified accreditation with the Care Quality Commission for 2011/12.

NHSLA

The NHSLA is the litigation authority which works to improve risk management practices in the NHS. Every NHS hospital is visited by independent assessors once every two 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.

Background and Context

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 and priorities

Our principal commissioner is NHS Suffolk, with whom we work in close constructive partnership and the majority of our income comes from the services they buy from us on behalf of Suffolk people. A small number of our patients live in the areas covered by neighbouring primary care trusts NHS Norfolk and Waveney, and NHS North East Essex.

NHS Suffolk wants to do the very best for Suffolk people and works together with the hospital and all other providers to improve patients' lives.

Its priorities in relation to the commissioning of acute services are reflected in the Service level Agreement. These requirements are also highlighted by NHS Midlands and East Strategic Health Authority's Commissioning Framework which in some areas, notably infection rates, seeks performance significantly better than that required by the Department of Health.

The wider intentions of the NHS Suffolk are set out in the Local Delivery Plan (LDP) which reflects the four main national priorities:

- better prevention services with earlier intervention;



Stroke Team.

Background and Context

- giving people more choice and a greater influence on their own healthcare;
- tackling inequalities and improving access to community services; and
- providing more support for people with long-term health needs.

with local people and partners. The goals and initiatives being taken forward by NHS Suffolk are reflected in the hospital's vision and together we share a joint ambition to make sure people in Suffolk have access to high quality healthcare services which we both want to see delivered locally whenever possible, and centralised only where it is clinically appropriate. We are committed to working together to make the best use of public resources in these challenging times.

NHS Suffolk has a clear strategy, Your Care Matters, which embraces the wider ambitions of the NHS Midlands and East Clinical Vision – Towards the Best, Together – alongside the local priorities which it has developed



Fragility Fracture Team.

Key Relationships

Staff

Just over 3,000 whole time equivalent members of staff are employed by the hospital. Around 360 volunteers also make a real difference to the lives of patients in hospital and to staff.

Staff involvement and engagement in the hospital is vital to its success. We continue to strengthen staff communications and produce Our Week Ahead – a weekly newsletter from the Chief Executive as well as Loud and Proud – a review of news and happenings sent at the end of each week.

Regular forums are also held for staff to debate issues of importance and interest with senior executives, and the Joint Consultative/Negotiating Group (JCNG), meets monthly.

Equality lies at the heart of the services we provide – our values, processes and behaviours. The hospital has adopted the Equality Delivery Scheme to assist in embedding this vision of a better, personal and fair hospital, and working to deliver our aim of making sure everyone counts.

We work closely within the local health economy to provide a network of support across the county and we have a Patient Experience Group and many other patient groups such as one focusing on Respecting Diversity, which looks at how we

respect different cultures and traditions. The hospital is an equal opportunities employer and has a range of employment policies and practices in place to make sure that our commitment to equality of opportunity is promoted in our workplace.

We are committed to an inclusive approach, making sure that no job applicant or employee receives less favourable treatment because of their sexuality, marital or family status, age, disability, race, colour, gender, gender reassignment, sexuality, nationality, ethnic origin, creed, religion, faith or belief.

The Trust has a sickness absence rate of 4.18% for 2011/12. This compares favourably with other similar trusts.

Here are more details about the sickness absence rate – 2011/12:

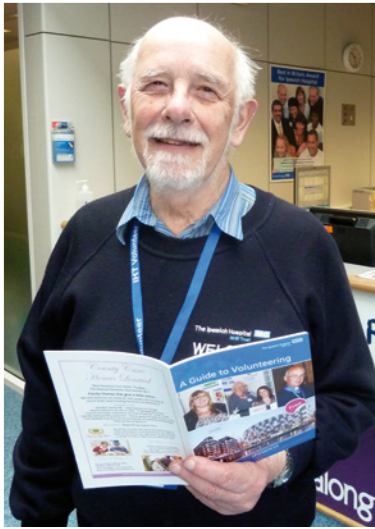
The Trust ensures it provides a range of health and wellbeing schemes, policies and benefits to all employees. This supports one of the staff pledges within the NHS Constitution “to provide support and opportunities for staff to maintain their health, wellbeing and safety”. It also supports the four key facets of quality, innovation, productivity and prevention and will contribute to the success of the organisation.

A Wellbeing Programme for all staff is established throughout the Trust. A group of colleagues



Sharon Randall, Coloproctology Nurse Specialist Secretary.

Key Relationships



Peter Brunning,
Volunteer.

within the Trust who have a particular interest in health and wellbeing lead the programme. Colleagues include clinical staff, managers, support staff, union representatives and an ISS (facilities management partner organisation) representative.

Wellbeing events include exhibitions with information and advice on fitness and diet, green travel, mental health, back care, Hospital book club, healthy snacks/healthy lunchboxes, blood pressure checks, smoking cessation.

A Walking Route around the hospital has been developed. The Walking Route takes about 25 minutes (3000 steps) to complete and it can be also be split into sections. A Walking Route Map was produced which includes a section for people to record their walks.

The Trust has committed to both the Healthy Ambitions and Mindful Employer initiatives. Staff have access to work life balance provisions, employee welfare services and healthy workplace initiatives including: flexible working arrangements, self referral physiotherapy, counselling support, and on-site yoga classes. This year, the Trust was awarded a Healthy Ambitions Suffolk Gold Award in recognition of its wellbeing programme.

Education and training for all staff is available. The work of the Trust's Education and Training

team is built on its accredited professional library and learning resources service and has enjoyed another busy and successful year.

Our Information, Advice and Guidance service, which helps staff make informed choices regarding their personal development and career aspirations has been successfully reassessed against national standards and ensures another three years on-site accredited service for staff.

All staff have been encouraged to engage in learning. We have also provided local learning providers with apprenticeship placements

The on-going development of the teaching programme offered by the Postgraduate Centre continues to support the modernisation of medical careers and we now host medical students based at the University of East Anglia as well as the University of Cambridge.

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,



Etaine Connolly,
Registered nurse.

Key Relationships

surveys and the Hospital Advice and Complaints Service) 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 Suffolk LINK 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. 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 in-house and national patient surveys, monitoring of complaints and compliments and 'Your Views Matter' comment cards on wards.

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.

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 NHS commissioners, GP commissioners, NHS Midlands and East (Strategic Health Authority cluster) and local authorities, we have strategic alliances with universities and colleges, particularly University Campus Suffolk, and medical schools.

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).

Key Relationships

The sustainable key actions are as follows:

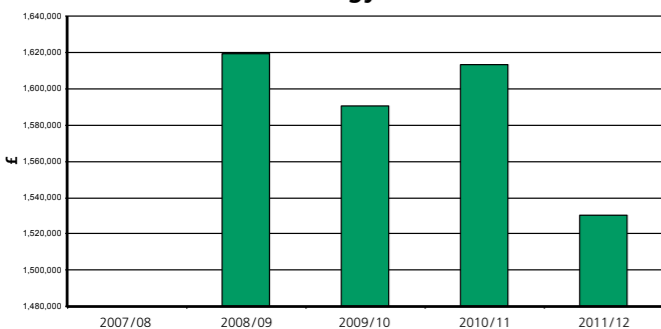
- The Trust has developed a Carbon Reduction Plan to achieve a 20% reduction in emissions in line with government national targets for the NHS.
- The Trust has calculated its carbon footprint.
- An action plan of projects has been developed to deliver the required carbon reduction targets.
- A sustainability policy is being developed.
- The Trust will sign up to the Good Corporate Citizen Assessment Test and develop an action programme based upon the results.
- The Trust will carry out benchmark comparisons against similar Trusts.
- The Trust will continue to work with the Carbon Trust.

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

Sustainability Report

5%

Total Energy Costs



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.

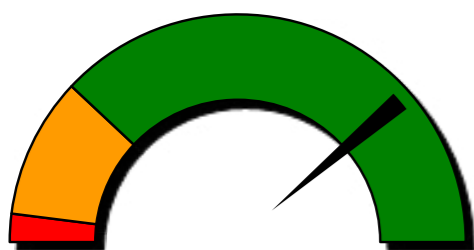
By reducing our energy costs by 5% in 2011/12, we have saved £83,448, the equivalent of 15 hip operations.

£763,290

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 10 years we expect to save £763,290 as a result of these measures.

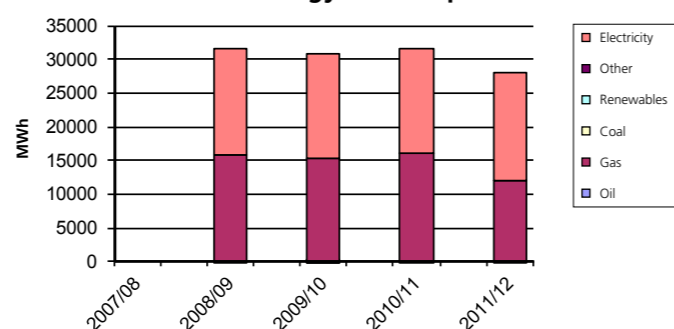
962 tonnes

We recover or recycle 962 tonnes of waste, which is 76% of the total waste we produce.



Our total energy consumption has fallen during the year, from 31,487 to 27,953 MWh.

Total Energy Consumption

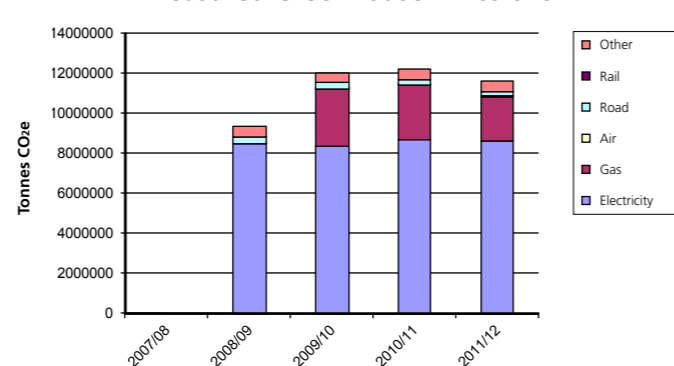


Our relative energy consumption has changed during the year, from 0.32 to 0.29 MWh/square metre.

Renewable energy represents 0.0% of our total energy use. We do not generate any energy. We have not made arrangements to purchase electricity generated from renewable sources.

Our measured greenhouse gas emissions have reduced by 551,681 tonnes this year.

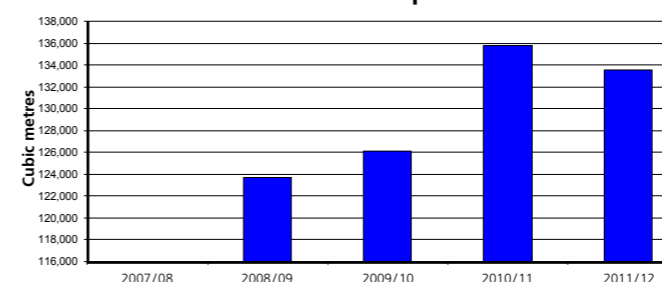
Measured Greenhouse Emissions



Our water consumption has reduced by 2,268 cubic meters in the recent financial year. In 2011/12 we spent £287,419 on water. (See chart on next page.)

Sustainability Report

Water Consumption



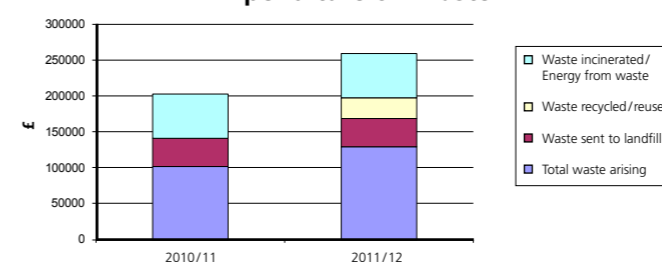
During 2011/12 our gross expenditure on the CRC Energy Efficiency Scheme was £137,000.

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 2011/12 our total expenditure on business travel was £9,870.

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

Expenditure on Waste



Our organisation is developing a sustainable development 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.

John Watson 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 not currently included in the job descriptions of all staff. "A sustainable NHS can only be delivered through the efforts of all staff."

Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

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.

Structure and Management

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

Mike Brookes retired on 31 December 2011. Dave Norval was Interim Chairman from 1 January 2012 until Ann Tate CBE, took up her new appointment as Trust Chair on 2 April 2012.

All non-executive directors are appointed by the NHS Appointments Commission. Each post is widely advertised in the media and applications are encouraged from anyone who feels they have skills and expertise which will benefit an NHS Trust. Open competition and a selection process designed to ensure fairness and equality is in place.

The Chairman 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 Chairman.

The Audit Committee's membership is all of the non-

Chairman and Non-Executives

Mike Brookes	Chairman*
Dave Norval	Deputy Chairman
Julia Holloway	Non-Executive Director
Alan Bateman	Non-Executive Director
Tony Thompson	Non-Executive Director
Andrew George	Non-Executive Director

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.

Trust Executive Directors

Andrew Reed*	Chief Executive
Peter Donaldson	Trust Medical Director
Siobhan Jordan	Director of Nursing and Quality, Infection Prevention and Control
Stephanie Watson	Director of Finance and Performance
Julie Fryatt	Director of Human Resources
John Watson	Director of Operations **
Andy Burroughs	Director of Business Development **

* Andrew Reed left the Trust on 18 May 2012 to take up a Programme Director role with NHS Midlands and East. Nigel Beverley took up his role as Interim Chief Executive on 21 May 2012.

** Non-voting board members. Andy Burroughs left the Trust on 14 April 2012.

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.

Details of directors remuneration are given on page 38 of this report.

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.



Gillian Clarke,
Service manager,
Occupational Therapy Services.

Structure and Management



Sally Talbot,
Administration Coordinator
(Acute Medical Unit).

There are seven business units with an executive support unit.

Senior colleagues in each business unit are:

General Acute Services and Pain which includes accident and emergency, assessment units, theatres and anaesthetics, critical care and pain management.

Clinical Chair **Tony Nicholl***

General Manager **Wendy Webb****

The Head Matrons appointed for this unit are:

Phil Windsor Theatres and Anaesthesia

Caroline Driver Emergency Medicine.

*Tony Nicholl retired as Clinical Chair from 21 March 2012. Nicola Trepte and Martin Mansfield took up their job share role as Clinical Chair on 1 April 2012.

** Wendy Webb took up her new role as Senior Projects Manager on 7 May 2012. Brian Owens, Associate Director of Operations, took over as General Manager from this date.

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

Clinical Chair **Issam Osman** (from April 2011)

General Manager **Jim Craig**

The Head Matron appointed for this unit is **Sarah Seeley**.

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

Clinical Chair **Rob Mallinson**

General Manager **Anna Bjorkstrand***

The Head Matrons are:

Caroline Vergo and **Fran Friston**.

*Anna Bjorkstrand took up a new role as Business Development Manager from 16 April 2012. Carolyn Cozens is Acting General Manager.

Structure and Management

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

Clinical Chair **Mahmoud Salam**

General Manager **Neil Harris**

The Head Matron is **Tracey Wakeling**.

Musculoskeletal Services which includes trauma and orthopaedics, and rheumatology.

Clinical Chair **Mike Shanahan**

General Manager **Robert Power**

The Head Matron for this unit is **Jan Wright**.

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

Clinical Chair **Andy Leather**

General Manager **Trish Curtis**

The Head Matrons appointed to this unit are:

Karen Wolfe, and **Chris Colbourne** (Head of Midwifery)

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

Clinical Chair **Chris Scrase**

General Manager **Jane Micheal**

The Head Matrons for this unit are **Sam Bower** and **Gill Heard**.



Tracey Wakeling,
Head matron, Special Surgery.

Structure and Management



Barrie Fisk,
Procurement and Logistics Manager.

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 has a governance group and together they have a vital role in bringing change, and considering clinical developments, service improvements, risk management and internal control issues throughout the Trust. The Trust complies with the clinical governance reporting framework issued in November 2002.

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 is now managing the complaints process much more closely than in previous years, ensuring the process is fair, consistent and timely. Much support is being offered to business units in handling complaints which is welcomed. Feedback from staff, patients and relatives has generally been very good.

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

High level

Multiple issues relating to a longer period of care including an event resulting in serious harm. *Dealt with by the Complaints Team.*

Medium level

Several issues relating to a short period of care including, for example, failure to meet care needs, medical errors, incorrect treatment or attitude of staff or communication. *Dealt with by the Complaints Team.*

Low level

Simple, non-complex issues including, for example, delayed or cancelled appointments, lack of cleanliness, transport problems. *Dealt with by the PALS Team.*

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

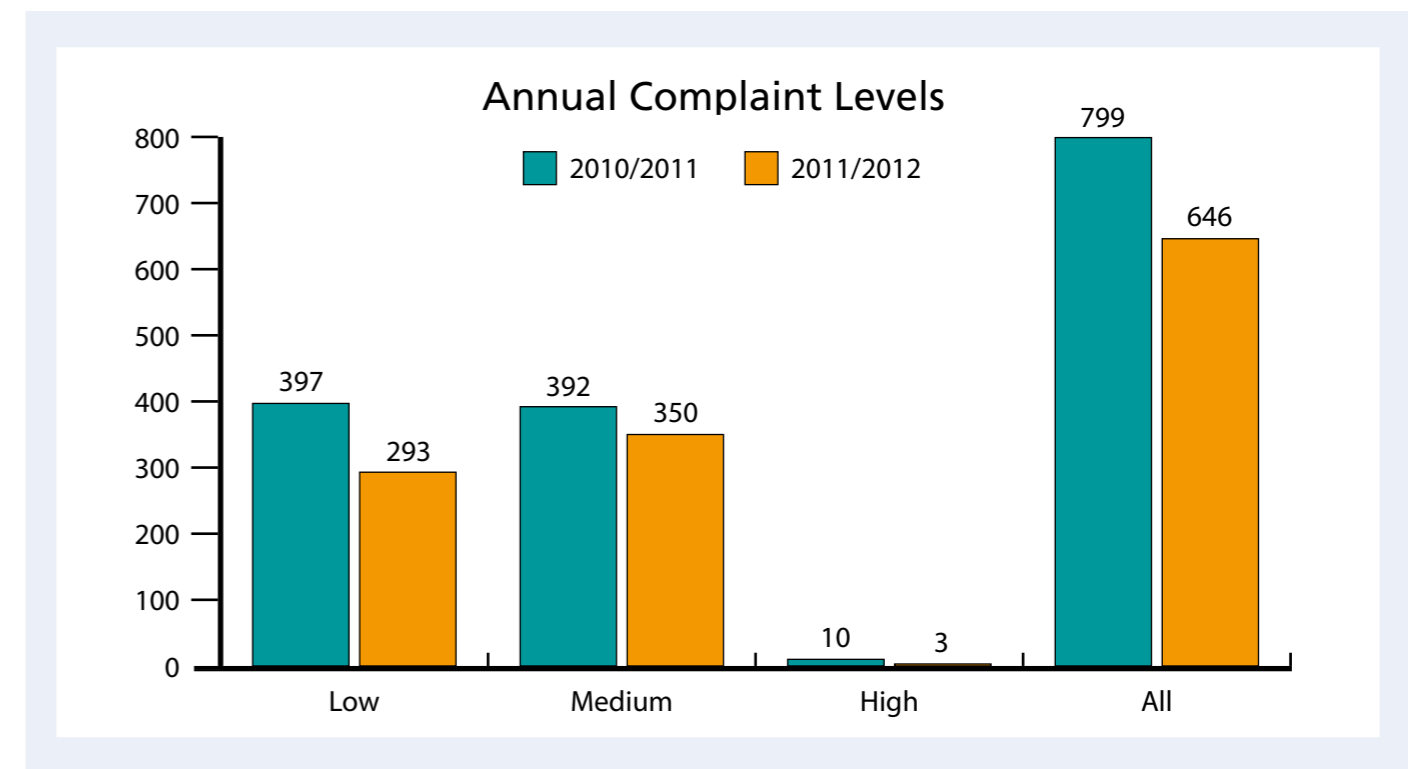
The number of complaints dropped by 20% in 2011/12 compared to the previous year (799 in 2010/11 and 646 in 2011/12). This has been mainly due to a significant improvement in our PALS service, which prevents issues escalating to formal complaints. The PALS

service handles 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 team welcome feedback and complaints verbally, in person or in writing and every complaint is acknowledged within 72 hours. A meeting is offered on request within each acknowledgment letter.

The complaints and PALS team attend wards and departments regularly to support staff in handling negative feedback from patients and relatives to encourage local resolution. As

Structure and Management



Structure and Management

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.

If a complainant wishes to take their complaint further we advise them they can contact the Parliamentary and Health Service Ombudsman (PHSO). In 2011/12 14 complaints were taken to the PHSO. Of these, seven were closed without investigation and four were looked into and led to a request for the Trust provide a further response, which was provided. The remaining three cases are being reviewed at present.

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. The table (right) outlines some specific examples of this:

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 NHS Suffolk our commissioners, and NHS Midlands and East.

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.

Complaint	Action taken
The contact details on the website for complaints were not up to date and clear.	All details were reviewed and all pages have been updated.
The temperature in the Renal Unit was too cold.	Ceiling vents have now been changed so that they no longer point straight down and actually disperse the air around the room. Also there has been new digital thermometers which are checked regularly.
There was nowhere on site for visitors to smoke.	Smoking shelter by ED has been erected.
You told us staff in the Courtyard restaurant had not had first aid training.	All staff have now been given or have arranged to be given basic first aid training.
You were worried about your car park ticket running out when you were in clinic.	Posters have been displayed Trust-wide advising people that they do not need to extend their ticket if their clinic over-runs and advising them to contact PALS should they receive a penalty unfairly.

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 MRSA bacteraemia (blood-borne infections) and C. difficile very significantly and met both targets.

Key facts and figures

Births: 3,872
Emergency Department attendances: 63,263
Planned admissions: 46,686
Unplanned emergency admissions: 27,951
Outpatient attendances: 429,468
Number of appointments people did not attend: 30,959
Diagnostic Imaging examinations: 209,007
Referrals: 126,250

Performance

Performance

Key Standards				Year 2010/11	Year 2011/12	2011										2012		
Access and Standards	Indicator	Standard	Achieved			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Healthcare-acquired infections	MRSA bacteraemia rate	Meet trajectory	✓	1	2	0	1	1	0	0	0	0	0	0	0	0	
		MRSA screening all elective inpatients	100%	X*	100%	99%	98.69%	98.08%	98.37%	98.80%	98.47%	97.57%	98.63%	99.00%	99.34%	98.84%	99.17%	99.49%
		Clostridium difficile	Meet trajectory	✓	49	29	4	2	3	3	1	3	3	0	1	4	4	1
Patient Experience	Patient identification	Use of national NHS number	99%	✓	99%	99%	99.36%	99.33%	99.26%	99.27%	99.27%	99.23%	99.27%	99.40%	99.27%	99.26%	99.30%	99.47%
	Same-sex accommodation	Maintain same-sex accommodation	Meet trajectory	X*	0	12	0	0	0	0	0	0	0	0	12	0	0	
Patient Experience	18-week wait milestones	Admitted patients treated within 23 weeks	95%	✓	94%	98%	99.59%	99.25%	99.47%	99.40%	99.14%	99.04%	99.13%	98.63%	99.21%	96.29%	96.52%	96.11%
		Non-admitted patients treated within 18.3 weeks	95%	✓	98%	99%	98.53%	98.79%	99.26%	99.22%	98.81%	98.92%	99.07%	99.40%	99.52%	99.51%	99.85%	99.28%
Quality	Stroke	Percentage of patients staying 90% on stroke ward	80%	✓	69%	90%	92.59%	94.12%	80.49%	94.44%	90%	85.96%	80.65%	97.22%	93.94%	83.78%	93.33%	93.94%
		Percentage of High Risk TIA patients who are scanned and treated within 24 hours	60%	✓	35%	77%	71.43%	66.67%	70%	100%	88.89%	83.33%	71.43%	62.50%	91.67%	71.43%	87.50%	64.29%
Quality	Venous thromboembolism (VTE)	Percentage of patients screened on admission	90%	✓	93%	96%	88.82%	94.40%	96.02%	96.27%	95.35%	96.76%	97.54%	97.84%	97%	97.37%	97.38%	98.29%
	Cancer	2-week wait – suspected cancer	93%	✓	94%	95%	94.80%	94.17%	93.72%	94.81%	95.45%	94.93%	97.28%	95.58%	96.09%	94.97%	92.97%	93.97%
		2-week wait – symptomatic breast	93%	✓	94%	96%	92.22%	92.55%	94.17%	100%	95.24%	95.24%	98.61%	95.89%	95.16%	97.37%	100%	93.51%
		31 day-to-treatment performance	96%	✓	99%	99%	100%	100%	100%	97.53%	100%	99.46%	97.89%	100%	98.58%	98.48%	96.50%	100%
		62 day-to-treatment performance	85%	✓	90%	90%	92.14%	93.06%	87.26%	89.19%	93.68%	93.24%	86.61%	92.90%	92.72%	80.99%	87.10%	87.35%
	Cardiac care	Rapid Access Chest Pain Clinic	100%	✓	100%	100%	100%	100%	100%	98.18%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency care	4-hour A&E target	95%	✓	97%	96%	96.05%	96.29%	96.24%	95.84%	98.57%	98.52%	97.65%	96.51%	94.47%	95.35%	93.33%	97.66%	

Trust Efficiency and Productivity Targets				Year 2010/11	Year 2011/12	2011										2012		
Efficiency and Productivity	Indicator	Target	Achieved			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Flow	Rate at which patients did not attend	N/A	✓	8%	6%	6.32%	6.22%	6.45%	6.32%	6.51%	6.42%	5.91%	5.45%	5.24%	5.58%	4.84%	4.95%	
	Day surgery (Trust-wide rate)	> 75%	✓	81%	85%	84.89%	84.87%	84.18%	83.78%	84.61%	85.51%	84.99%	84.12%	85.79%	84.43%	86.81%	85.70%	
	Delayed transfers of care (DTOCs)	No more than 3%	✓	2%	2%	1%	2.54%	2.76%	1.92%	1.29%	1.82%	1.85%	1.35%	0.20%	2.07%	1.15%	1.89%	
	Cancelled operations	< 1%	✓	0.73%	0.76%	0.63%	0.94%	0.67%	0.93%	0.32%	0.47%	0.50%	0.98%	0.82%	0.92%	0.68%	1.22%	
	Appointment following cancellation 5-day standard	0	X*	7%	3%	13.64%	5.56%	0%	8.57%	7.69%	0%	0%	0%	0%	0%	4.17%	1.96%	
	Appointment following cancellation 28-day standard	0	X*	10%	2%	4.55%	0%	0%	0%	7.69%	5.26%	0%	0%	3.57%	0%	4.17%	0%	
	Choose & Book outpatient booking breaches	No more than 4%	✓	17%	4%	4.31%	4.02%	8.17%	6.40%	8.58%	6.84%	1.64%	0.78%	1.30%	0.24%	0.24%	0.31%	
Workforce	Whole-time equivalent (WTE) staff in post	N/A	✓	3201	3170	3233	3233	3208	3217	3193	3198	3173	3175	3154	3109	3079	3066	
	Completion of mandatory training	95%	X*	82%	81%	78%	79%	80%	80%	80%	81%	81%	80%	78%	76%	89%	89%	
	Completion of staff Personal Development Reviews	85%	✓	77%	86%	87%	87.50%	88%	89%	89%	88%	89%	91%	90%	89%	74%	75%	
	Sickness absence	< 3.5%	X*	4.06%	4.04%	3.26%	3.08%	3.54%	3.71%	3.76%	4.12%	4.40%	4.52%	5.01%	4.56%	4.24%	4.23%	

These are all national standards and are calculated on an agreed national basis. Our performance for 2010/11 can be found in last year's Annual Report.

* Action plans in place to ensure compliance.

Operating Financial Review

With a surplus of £729,000, 2011/12 was the sixth year in a row in which Ipswich Hospital reported a positive financial outturn. However, as the Chief Executive has already discussed, this was not without considerable support from NHS Suffolk and NHS Midlands & East.

This support did however enable us to deliver all our key financial targets again:

Key target	Requirement	Result	Achieved?
Income and expenditure surplus	Break-even	£729k surplus	Yes
Capital cost absorption rate	3.5%	3.5%	Yes
External financing limit	Less than £7.1m	-£2.1m	Yes
Capital resource limit	Up to £13.5m	£10.6m	Yes

To achieve this, we delivered savings of £12m, nearly £4.4m higher than last year. These were ongoing budget reducing savings and exclude the savings delivered to recover previous overspends as part of the financial recovery programme. Some of the actions taken to recover the financial position include:

- Reducing reliance on agency staff, saving nearly £500,000 a month between the start and the end of the year.
- Reducing reliance on additional session payments (overtime) to medical staff, saving over £100,000 a month on payments to hospital consultants.
- Improving productivity thereby reducing our reliance on outsourcing to achieve access targets, saving over £100,000 a month.
- 86 redundancies, of which 82 were voluntary, on top of strict recruitment controls to maximise redeployment opportunities across the hospital, with the biggest cuts affecting admin staff.

Our income rose by over £3m in the past year. However this reflected the receipt of £5.5m of support from the SHA, and £3m to cover

the cost of redundancies and other transformation costs from the PCT, offsetting reductions in clinical income including a £4m drop in income from emergency patients.

Our operating costs rose by £3.6m, which included £2.5m of additional termination payments. Without this employee pay costs overall reduced by £2.3m reflecting the reduction in staff numbers between this year and last year. Supplies and services costs (eg bandages, drugs and medical equipment) rose by over £3m, even though overall activity was down, due to rising prices and the VAT impact.

During the year, despite the turbulent financial position, we ended the year slightly down at £10.3m in the bank from £12.6m at the beginning. However our Better Payment Practice Code performance dropped slightly with the number of invoices paid within 30 days reducing from 93% to 89%. We did continue to prioritise payments to local businesses paying over 63% by value within 10 days against the target of 60%.

The Trust also met its £3.3m repayment on its working capital loan with the Department of Health.

The Trust spent over £10.5m on improving its assets with £1.2m

spent on new state-of-the-art digital mammography equipment and over £1.8m on a cutting-edge linear accelerator for the treatment of cancer patients. A further £1.1m was invested in information technology, £1.0m on new equipment and £1.8m on developing the estate. The Trust also secured £10m in funding for our new Cardiology centre, and a new decontamination facility, and work has started on these already.

However 2011/12 was the year when Ipswich Hospital really saw the new economic reality bite. Although we met all our key financial targets it was not without considerable pain, effort and support. We still carry the burden of our legacy debt, which stands at just over £3.6m, and each

year the Trust is hit by the double whammy of falling prices (1.8% in 2012/13 reflecting a 4% efficiency assumption) and falling activity levels as the PCT's schemes to move care closer to home and reduce unnecessary hospital admissions take hold.

2012/13 will therefore be a year of transition for the Trust. The continuing financial challenge means we must find £22m of savings in order to deliver our planned break-even position, let alone cover the cost of our loan repayment. With the financial climate being described by the Financial Times as 'a decade of no money' we must come to terms with the harshness of the financial climate within the NHS and wider

public sector. Therefore we have engaged a team of experts to help us find the savings we need, and to help us identify the future size and shape of Ipswich Hospital.

This will be a year of listening to our stakeholders, and planning for a different future, but being ruthless in cutting waste and inefficiency and delivering the toughest financial challenge we've ever seen to secure the future of our hospital.



John Butcher, Chief Biomedical Scientist (Haematology).

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 2012, a copy of which can be obtained from:

Stephanie Watson

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 2011/12 were £149,000 (2010/11 £158,000).

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 2012 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the related notes and the information in the Remuneration Report that is described as having been audited.

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.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements and the Directors' 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 chief executive's overview, background and context, key relationships, sustainability report, structure and management, performance, operating financial review, declaration of interests, glossary of terms and thank you to.

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 statutory financial statements describes the basis of our audit opinion on those financial statements, the Directors' Report and the Directors' Remuneration Report.

Our Accounts

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements and the Directors' Remuneration Report of the Ipswich Hospital NHS Trust for the year ended 31 March 2012 and complies with the relevant requirements of the directions issued by the Secretary of State.



**C McLaughlin,
Director**

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

Date: 11 June 2012

Our Accounts

Directors' statement

The auditors have issued unqualified reports 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 statements on matters on which they are required, by the Code of Audit Practice, to report by exception:

- the auditors have qualified their conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness because in their view in considering the Trust's arrangements for securing financial resilience, they identified that the Trust does not have robust plans in place to achieve approximately £9.8m of its target savings of £22m for 2012/13.

Our Accounts

Statement of Comprehensive Income for the Year Ended 31 March 2012

	2011 / 12 £000	2010/11 £000 (restated)
Employee benefits	(144,531)	(144,312)
Other costs	(87,199)	(83,829)
Revenue from patient care activities	213,928	216,112
Strategic Transformation Funding	5,500	0
Other Operating revenue	18,722	19,022
Operating surplus / (deficit)	6,420	6,993
Investment revenue	32	50
Other gains and (losses)	(3)	(43)
Finance costs	(2,234)	(2,307)
Surplus / (Deficit) for the financial year	4,215	4,693
Public dividend capital dividends payable	(3,486)	(3,435)
Retained surplus / (deficit) for the year	729	1,258
Other comprehensive income		
Impairments and reversals	(6,099)	0
Net gain/(loss) on revaluation of property, plant & equipment	7,842	200
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Net gain/(loss) on other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Total comprehensive income for the year	2,472	1,458
Financial performance for the year		
Retained surplus/(deficit) for the year	729	
Prior period adjustment to correct errors	0	
IFRIC 12 adjustment	(1,192)	
Impairment reversals	600	
Adjustments to donated asset/government grant reserve elimination <i>[if required]</i>	0	
Adjusted retained surplus / (deficit)	137	

Our Accounts

Our Accounts

Statement of Financial Position as at 31 March 2012

	31 March 2012 £000	31 March 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets:			
Property, plant and equipment	141,581	137,192	136,366
Intangible assets	4,805	5,306	5,495
Investment property	0	0	0
Other financial assets	0	0	0
Trade and other receivables	780	549	546
Total non-current assets	147,166	143,047	142,407
Current assets:			
Inventories	3,764	3,582	3,025
Trade and other receivables	5,881	10,186	16,165
Other financial assets	0	0	0
Other current assets	0	0	0
Cash and cash equivalents	10,330	12,555	11,676
Total current assets	19,975	26,323	30,866
Non-current assets held for sale	0	0	0
Total current assets	19,975	26,323	30,866
Total assets	167,141	169,370	173,273
Current liabilities:			
Trade and other payables	(13,300)	(15,773)	(16,294)
Other liabilities	0	0	0
Provisions	(582)	(135)	(140)
Borrowings	(1,398)	(1,204)	(1,386)
Other financial liabilities	0	0	0
Working capital loan from Department	(3,342)	(3,342)	(3,342)
Capital loan from Department	0	0	0
Net current liabilities	(18,622)	(20,454)	(21,162)
Non-current assets plus/less net current asset/liabilities	148,519	148,916	152,111
Non-current liabilities:			
Trade and other payables	(481)	0	0
Other liabilities	0	0	0
Provisions	(1,199)	(1,247)	(1,317)
Borrowings	(29,238)	(29,198)	(30,489)
Other financial liabilities	0	0	0
Working capital loan from Department	(3,348)	(6,690)	(10,032)
Capital loan from Department	0	0	0
Total non-current liabilities	(34,266)	(37,135)	(41,838)
Total Assets Employed:	114,253	111,781	110,273
FINANCED BY TAXPAYERS' EQUITY:			
Public dividend capital	74,533	74,533	74,483
Retained earnings	(16,993)	(20,987)	(26,043)
Revaluation reserve	56,713	58,235	61,833
Other reserves	0	0	0
Total taxpayers' equity	114,253	111,781	110,273

The summary financial statements on pages 34–38 have been approved by the Board.



Interim Chief Executive
Nigel Beverley
Date: 7 June 2012

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2012

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2011	74,533	(20,987)	58,235	0	111,781
Opening balance adjustments		0	0	0	0
Adjustments for Transforming Community Services transactions		0	0	0	0
Restated balance at 1 April 2011	74,533	(20,987)	58,235	0	111,781
Changes in taxpayers' equity for 2011-12					
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	0
Net recognised revenue/(expense) for the year	0	3,994	(1,522)	0	2,472
Balance at 31 March 2012	74,533	(16,993)	56,713	0	114,253
Changes in taxpayers' equity for 2010-11					
Balance at 1 April 2010	74,483	(26,043)	61,833	0	110,273
Retained surplus/(deficit) for the year		1,258			1,258
Net gain/(loss) on revaluation of property, plant, equipment			200		200
Transfers between reserves		3,798	(3,798)	0	0
New PDC Received	50				50
Net recognised revenue/(expense) for the year	50	5,056	(3,598)	0	1,508
Balance at 31 March 2011	74,533	(20,987)	58,235	0	111,781

Retained earnings relate to the cumulative deficit made by the Trust since its inception.

The revaluation reserve reflects movements in the value of property, plant and equipment and intangible assets as set out in the accounting policy. The revaluation reserve balance relating to each asset is released to retained earnings on disposal of that asset and as depreciation is charged on the revalued element.

Our Accounts

Our Accounts

Statement of Cash Flows for the Year Ended 31 March 2012		
	2011/12 £000	2010/11 £000
Cash flows from operating activities		
Operating surplus/deficit	6,420	6,993
Depreciation and amortisation	9,471	9,112
Impairments and reversals	(600)	0
Donated assets received credited to revenue but non-cash	(439)	(156)
Interest paid	(2,219)	(2,296)
Dividends paid	(3,398)	(3,607)
(Increase) in inventories	(182)	(557)
Decrease in trade and other receivables	3,986	6,147
(Decrease) in trade and other payables	(2,450)	(663)
Provisions utilised	(2,401)	(113)
Increase in provisions	2,770	27
Net cash inflow / (outflow) from operating activities	10,958	14,887
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	32	51
(Payments) for property, plant and equipment	(8,503)	(8,805)
(Payments) for intangible assets	(247)	(518)
(Payments) for investments with DH	0	(35,000)
Proceeds from disposal of assets held for sale (PPE)	0	29
Proceeds from disposal of investments with DH	0	35,000
Net cash inflow / (outflow) from investing activities	(8,718)	(9,243)
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	2,240	5,644
Cash flows from financial activities		
Public divided capital received	0	50
Loans repaid to the 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	(1,562)	(1,473)
Capital grants and other capital receipts	439	0
Net cash inflow / (outflow) from financing activities	(4,465)	(4,765)
NET (DECREASE) / INCREASE IN CASH AND CASH EQUIVALENTS	(2,225)	879
Cash and cash equivalents (and bank overdraft) at the beginning of the period	12,555	11,676
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0
Cash and cash equivalents (and bank overdraft) at year end	10,330	12,555

Better Payment Practice Code				
Measure of compliance	2011 / 12		2010 / 11	
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	60,716	101,000	60,721	86,847
Total non-NHS trade invoices paid within target	54,011	88,000	56,219	77,680
Percentage of non-NHS trade invoices paid within target	88.96%	87.13%	92.59%	89.44%
NHS Payables				
Total NHS trade invoices paid in the year	1,649	11,111	1,459	11,253
Total NHS trade invoices paid within target	1,366	9,655	1,230	9,805
Percentage of NHS trade invoices paid within target	82.84%	86.90%	84.30%	87.13%

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 or a valid invoice, whichever is later.

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 Chairman of the Trust, who acts as Chairman, and the Non-executive Directors of the Board. At the discretion of the Chairman, 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 Chairman (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 2011/12.

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 £13,368,382.55 to the Pensions Agency in the year. Note 8,5 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 2011/12	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	95–100			0
Andy Burroughs Director of Business Development	80–85			0
John Watson Director of Operations	95–100			0
Mike Brookes Chairman	15–20			6
Dave Norval Deputy Chair and Non-Executive Director Interim Chairman 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								
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.

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. In calculating the actuarial value of the CETV as at 31 March 2011 the NHS Pensions Agency has used the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI) as previously. This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption can lead to a decrease in the CETV value compared with the CETV as at 31 March 2010.

Median staff pay disclosure

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

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

* The banded remuneration of the highest paid director in The Ipswich Hospital NHS Trust in the financial year 2011/12 was £139,116.58 (2010/11, £140,736.00). This was 4.27 times (2010/11, 4.46) the median remuneration of the workforce, which was £32,532.17 (2010/11, £31,497.16).

** In 2011/12, 27 (2010/11, 43) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £142,778.10 to £213,642.80 (2010/11 £142,297.00–£231,102.90)

*Variance year on year to director pay reduction. All staff pay freeze for salaries greater than £21,000. Agenda for Change increments if applicable.

**Variance due to changes in additional sessions paid to consultant staff.

Remuneration Report

Salary and Pension Entitlements of Board Members 2010/11 (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
Gwen Collins Director of Nursing and Quality until 3 May 2010	10–15			17
Stephanie Watson Director of Finance and Performance	125–130			0
Siobhan Jordan Director of Nursing and Quality from 1 June 2010	75–80			0
Mike Brookes Chairman	20–25			10
Dave Norval Deputy Chair and Non-Executive Director	5–10			6
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			4

(a) Two individuals held the post of Director of Nursing and Quality during the year.

(b) Benefits relate to mileage allowances paid in excess of the Permitted Inland Revenue limits. Other benefits are in respect of lease cars.

*Clinical Excellence Awards (CEAs) are available at two levels – national and employer-based (local) awards. A level 6 award is an employer-based (local) award. Subject to service qualification criteria, all consultants in the Trust are eligible under their contract of employment to apply for a CEA. The merits of all applications are assessed using guidance and criteria determined nationally by the Advisory Committee on Clinical Excellence Awards. These criteria include contribution and development of the service, contribution to teaching and training, research and innovation and leadership and management of the service. The decision-making body for any award is the Local Awards Committee. This is constituted in accordance with the national guidance and includes a number of peers, other clinical staff, Directors, Lay Representatives and a Non-Executive Director.

In 2009 Peter Donaldson was successful in his application for a CEA which took his award level to a level 6.

Pension Benefits – Board Members 2010/11 (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 2011 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2011 (Bands of £5,000) £000	Cash equivalent transfer value at 31 March 2011 £000	Cash equivalent transfer value at 31 March 2010 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Andrew Reed	0–2.5	5–7.5	50–55	155–160	980	1,032	-51	0
Julie Fryatt	0–2.5	N/A	0–5	N/A	38	27	10	0
Peter Donaldson	0–2.5	2.5–5	45–50	145–150	1,071	1,115	-44	0
Gwen Collins	0–2.5	0–2.5	15–20	50–55	276	251	2	0
Stephanie Watson	0–2.5	2.5–5	30–35	95–100	539	564	-25	0
Siobhan Jordan	12.5–15	50–52.5	15–20	50–55	190	0	158	0

Remuneration Report

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

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

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

As disclosed in the Annual Governance Statement, the auditors have qualified their conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of its resources. The auditors' qualification concerns the criterion specified by the Audit Commission as to whether the Trust has proper arrangements for securing financial resilience. Action being taken by the Trust is summarised in the Annual Governance Statement.

Taking into account the matter set out in the above paragraph, to the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.



Interim Chief Executive
Nigel Beverley
Date: 7 June 2012

Annual Governance Statement 2011/12

The Board is accountable for internal control. 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 Board is comprised of a chair, five non-executive director members and five executive director members with two other executive director members without voting rights attending each meeting. The Chair has a second and casting vote. The Trust Secretary also attends all Board meetings. The Chair retired at the end of December when the Deputy Chair acted up as Interim Chair until the end of March. At the beginning of April a new Chair appointed through the Appointments Commission process joined the Trust. During the year a decision was made to disestablish the post of Director of Business Development which was one of the two executive director attendee posts at board meetings. Responsibilities were reallocated to other exec directors with a planned review in Autumn 2012.

Board meetings are held each month with a public session held bi-monthly. Board meetings follow a structured format with each meeting starting with patient safety issues, followed by matters of strategy, performance and corporate governance. In a bi-monthly in-confidence session the Board talks with a patient or carer on their experiences at the hospital. In addition on a bi-monthly basis the Board holds seminar sessions which provide an opportunity for

the Board to be briefed on a number of issues in depth. For example, during the year the Board has received a live demonstration of the risk register system to explain how risks are recorded and managed. Non-executive Directors are actively encouraged to suggest topics for the seminar sessions.

The Trust has five formally designated committees of the Board:

- Audit Committee
- Healthcare Governance Committee
- Remuneration and Terms of Service Committee
- Charitable Funds and Sponsorship Committee
- Conflicts of Interest Committee

The Audit and Healthcare Governance Committees are the main assurance committees reporting to the Board. The Audit Committee provides an independent review of the internal control environment within the Trust to provide the Board with assurance on compliance with relevant regulatory, legal and code of conduct requirements. In its 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 all five Non-executive Directors and is chaired by a Non-

executive Director. The Chief Executive, Director of Finance and Performance, Trust Secretary, Head of Internal Audit and a representative from the external auditors attend the Audit Committee Meetings. 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 and also as requested on exceptional items. The Non-executive Directors hold a pre-meeting to discuss matters prior to each Audit Committee Meeting. Committee attendance was a minimum of 80%. The Healthcare Governance Committee ensures that risk and governance activities are managed effectively and has a number of reporting committees. 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 Group, Clinical Effectiveness Group and Patient Experience Group which report into it. The Healthcare Governance Committee is chaired by a Non-executive Director, and all five 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 Director of Operations. The Trust

Annual Governance Statement 2011/12

Secretary attends the Healthcare Governance Committee meetings. The Head of Internal Audit has commenced attendance during the year to mirror their attendance at the Audit Committee. Attendance was typically 83%.

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 the unconfirmed minutes of both the Audit Committee and Healthcare Governance Committee at its next meeting following the committee meetings. The confirmed minutes of both committees are received by the Board in public session at the next public meeting following their confirmation. The highlights of the meetings are briefed to the Board and the Board may request further work on various issues which are raised.

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 usually discussed at the May committee meeting.

The Remuneration and Terms of Service 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. Attendance was 100%.

The Charitable Funds and Sponsorship Committee is responsible for the administration of any funds held on trust, either as charitable or non-charitable funds, in accordance with statutory and legal requirements or best practice required by the Charities Commission. In addition, it is currently leading on the development of the sponsorship strategy and relevant associated policies. Attendance averaged 50%.

The Conflicts of Interest Committee was established during the year in order 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. Attendance was 100%.

Formal evaluation of the Board was undertaken in May 2010, and during a number of observed sessions by independent consultants, the SHA and Monitor as the Board went through the Foundation Trust application process throughout 2011/12. There were no significant issue arising through this observation process. However with the appointment of a new Chair in April 2012 the Board has recognised the need for a revised formal evaluation

and this is planned to be undertaken in summer 2012 including a review against the Corporate Governance Code.

Risk assessment

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 opposite).

Risks scoring 15 and above (critical) migrate to the Board Assurance Framework and thereby inform the Trust Board agenda. Risks that have been added in 2011/12 are:

- Failure to deliver the planned financial plan for 2011/12 and financial duties.
- Impact on patient care due to patient flow and capacity issues within the Trust.
- Risk of Hospital Acquired Thrombosis (HAT) post various procedures associated with not prescribing extended venous thromboembolism (VTE) thromboprophylaxis.
- Deterioration in some quality metrics impacting on patient safety (due to number of open escalation beds).

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 Risk Management Committee reviews and manages all aspects of risk reporting and assurance, and reports to the Healthcare

Annual Governance Statement 2011/12

Table 1: 5X5 Risk Matrix

		Likelihood score				
		1: Rare	2: Unlikely	3: Possible	4: Likely	5: Almost Certain
Consequence score	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

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.

In October 2011 the Trust identified a level 3 Information Governance breach which was reported as a Serious Incident Requiring Investigation. The incident concerned a member of staff who was transferring records between the main hospital building and the medical records department. A gust of wind blew 5 pages of handwritten clinic lists from the trolley. Three pages were retrieved but two could not be found. Details of 34 patients in total were lost – the list contained names and hospital numbers only. No clinical, diagnosis or other sensitive information of any kind was lost. Trolley covers have now been purchased to reduce the risk of this recurring and to improve the protection of all records while in transfer.

In March 2012 the Trust identified a level 3 Information Governance breach which was reported as a Serious Incident Requiring Investigation. The incident related to a patient belongings book which was brought into the Trust by a

patient's relative. The book was returned to South Finance and had been found in a deceased relative's belongings. The book contained details of 24 patients – names and hospital numbers. Ward Clerk staff have undertaken further training and awareness of this issue.

The risk and control framework

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

- **Identification and reporting of risk** – Identification of the risks facing the Trust, working in a way that spreads the workload and ensures that the initial identification of risk is not too onerous;
- **Calculation of the importance of each identified risk** – Achieved by undertaking an assessment of the 'likelihood' of the risk occurring and determining the 'consequences' should the event occur, using a matrix based on the National Patient Safety Agency risk matrix;

Annual Governance Statement 2011/12

- **Confirmation or introduction of controls** – This stage of the cycle aims to confirm or introduce specific controls to measure and to manage known and identified risks. These controls (eg policy, procedure, reporting mechanisms) 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 Business Units and Directorate and the Trust's Risk Management Committee. The Healthcare Governance Committee and Trust Management Team are informed of all principal (extreme) risks on a bi-monthly basis or earlier if deemed necessary. The Trust's Audit Committee also receives a summary of risks at each meeting.

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 advised on matters relating to 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.

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. 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 IHUG, Suffolk County Council Overview and Scrutiny Committee, NHS Midlands and East 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. A plan to address weaknesses and ensure continuous improvement of the system is in place.

In summary, the Board reviews the BAF and receives minutes from both the Audit Committee and Healthcare Governance Committee. The Audit Committee review 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 also have a 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.

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

Although the Trust has delivered an operational surplus for the last five financial years, due to the deficits incurred in 2003/04 to 2005/06, the Trust remains in breach of its statutory duty under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 (the 'breakeven' duty). Our External Auditors issued a Public Interest Report in September 2006 which also constituted a referral to the Secretary of State, under section 19 of the Audit Commission Act 1998, advising of the likely breach of the statutory breakeven duty. In March 2007 the Department of Health granted the Trust a loan of £23.4m to assist with the Trust's cash position. This is repayable in equal instalments over a seven-year period. A further Section 19 report was issued in October 2011 highlighting issues with financial plans as outlined below.

During 2011/12 the Trust diverted significantly from its financial plan and had to implement a formal financial recovery plan. With strategic transformation support funds of £5.5m via the PCT to support the resulting costs associated with the implementation of the

Quality, Innovation, Productivity and Prevention programme introduced across the Suffolk healthcare system, and with agreeing a revised £193m block contract for clinical activity, less deductions related to contractual targets but excluding any activity related adjustments, the Trust has been able to reduce ongoing costs. However this also meant the Trust had to withdraw from Monitor's stage of the Foundation Trust application process and will agree a new Tripartite Formal Agreement with the Department of Health in June, and resulted in a qualified Value for Money conclusion from external audit. The causes of the divergence also included weaknesses in the Trust's business planning and performance management processes, and plans are being developed to strengthen both these areas.

During 2010/11 and 2011/12 the Trust entered into a contractual arrangement with an external healthcare provider. The contract was intended for an initial trial period only, but was extended without following due process as outlined in Standing Orders (SOs) and Standing Financial Instructions (SFIs). Two internal and two external investigations have been undertaken. The final investigation, undertaken independently, and drawing in the other three, concluded that although SOs and SFIs had been breached, there was no non-compliance with legal requirements, no suggestion of fraud or that the deal did not represent value for money, and there is no case for referral to professional bodies. However changes have already been implemented and further work will be undertaken following formal adoption of the final report received in May 2012.

In September 2011 the Care Quality Commission undertook a repeat inspection and undertook a review of all standards. Although all the pre-existing moderate and minor concerns were lifted, one new moderate concern was raised related to the need for further work in contractual developments between the Trust and commissioners to ensure people using services can be confident that the care, treatment and support provided to meet their assessed needs is robust and all those involved co-operate to ensure this happens. This work is ongoing in partnership with NHS Suffolk and Norfolk and Suffolk NHS Foundation Trust.

Accountable Officer:

Nigel Beverley

Organisation:

The Ipswich Hospital NHS Trust



Interim Chief Executive

Date: 7 June 2012

Declaration of Interests

Declaration of Interests 1 April 2011 to 31 March 2012

Mike Brookes Chairman (Left Trust 31/12/2011)	<ul style="list-style-type: none"> • Nil
Alan Bateman Non-executive Director	<ul style="list-style-type: none"> • Director of Sailtone Ltd
Andrew George Non-executive Director	<ul style="list-style-type: none"> • Law lecturer for Essex County Council • Director/Trustee of Suffolk Mind • Education Appeals Member for Suffolk County Council • Standards Committee Member of Babergh District Council
Julia Holloway Non-executive Director	<ul style="list-style-type: none"> • Self-employed consultant – Institute of Employment Studies • Employee of Geoff Holloway, Independent Financial Advisor • Treasurer – Otley PCCI • Trustee – Age UK Suffolk
Dave Norval Non-executive Director Interim Chair from 01/01/2012 to 31/03/2012	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Paid employee in Parasol Ltd • Trustee for the Melton Trust • Co-opted member of Melton Parish Council
Andrew Reed Chief Executive	<ul style="list-style-type: none"> • 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)
Peter Donaldson Medical Director	<ul style="list-style-type: none"> • Ipswich Urological Partnership 25% Equity Partner • Married to Rosemary Donaldson, Matron/Senior Manager at Suffolk Nuffield Hospital • Occasional work for Eastern Surgery Limited • Listed participant to Nuffield Hospitals Extended Choice Network
Julie Fryatt Director of Human Resources	<ul style="list-style-type: none"> • Advisor to Young Peoples' Health Project on ad hoc basis • Motor home rental business
Siobhan Jordan Director of Nursing and Quality/ Director of Infection Prevention and Control	<ul style="list-style-type: none"> • Nil
Stephanie Watson Director of Finance and Performance	<ul style="list-style-type: none"> • Office holder Friends of Withersfield • Office holder PCC St Marys Withersfield • Office holder Village Hall Management Committee Withersfield
Andy Burroughs Director of Business Development (Left Trust April 2012)	<ul style="list-style-type: none"> • Nil
John Watson Director of Operations	<ul style="list-style-type: none"> • Nil

Glossary of Terms

Glossary of Terms

The Ipswich Hospital NHS Trust	<ul style="list-style-type: none"> • Referred to as 'the Trust', 'the hospital' or 'we' throughout this report.
NHS Suffolk	<ul style="list-style-type: none"> • The Primary Care Trust for Suffolk
NHS	<ul style="list-style-type: none"> • National Health Service
GP	<ul style="list-style-type: none"> • General Practitioner
DH	<ul style="list-style-type: none"> • 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.

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

Further copies of this report are available from:

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This Trust is working towards equal opportunities.

Published: Autumn 2012