East Suffolk and North Essex NHS Foundation Trust

Annual Report and Annual Accounts

1 April 2021 – 31 March 2022

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East Suffolk and North Essex NHS Foundation Trust

Annual Report
Annual Accounts

1 April 2021 – 31 March 2022

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

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Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) offers confidential, on-the-spot advice and support to help patients, relatives and other visitors sort out any concerns they may have about their care.

You can contact PALS on Freephone 0800 783 7328 or by emailing pals@esneft.nhs.uk. Please state whether your email is about Ipswich or Colchester Hospital.

We care, do you?

Becoming a member of our foundation trust gives you the opportunity to get involved in decisions that affect the services that we provide to you and your family. Membership is open to anyone over the age of 16 who lives in our area.

To find out more, email ft.membership@esneft.nhs.uk, phone 01206 742347 or visit www.esneft.nhs.uk and click on “get involved”.

General information and inquiries

Email: communications@esneft.nhs.uk

Full contact details and more contact information is available at www.esneft.nhs.uk

You can read ESNEFT’s Quality Account for 2021/22 at www.esneft.nhs.uk

For a copy of this annual report in Braille, large print or foreign language formats, please call 01473 704770

A welcome from the chair

On the very last day of the year covered by this annual report, 31 March 2022, we held an amazing event to celebrate staff at ESNEFT. The staff awards attracted hundreds of high calibre nominations and the whole event showcased the innovation, optimism and excitement of our colleagues.

We held the awards virtually because of the continuing rising transmission rates of COVID-19, and were joined by almost 1,000 people on the night. Another 1,100 people also viewed the event on YouTube in following days.

This celebration of our colleagues seemed to me a very good starting point for my address. I began my career in the NHS as a student nurse before becoming a midwife. I then worked in leadership roles in social care. My clinical background has helped me appreciate how difficult it has been at times this year and I continue to be amazed by the people I work with every day.

There has been much to celebrate in our Trust. Our £130m building programme over the next five years is really taking shape and the landscapes of both Colchester and Ipswich hospitals are rapidly changing, with state-of-the-art new centres created with staff and patient involvement.

At Ipswich, we recently saw the start of building work on the new multi-million pound breast care centre. The centre will transform the experience patients have when they come to hospital by bringing all elements of breast care under one roof – the clinic, the imaging department and hospital breast screening. The project is a partnership between NHS funding from ESNEFT and a fundraising appeal called The Blossom Appeal by Colchester & Ipswich Hospitals Charity.

During the year, our new £5.3m molecular laboratory at Ipswich Hospital also opened to create a permanent facility for COVID-19 testing and other molecular diagnostic services. And at Colchester Hospital, our new £8.9m combined interventional radiology and cardiac angiography (IRCA) Unit for peripheral vascular disease and other major diseases like aortic aneurysms was completed. This means that patients can be treated without an open operation by using modern techniques of interventional radiology. We also saw the completion of the new £960k pathology laboratory at Ipswich Hospital for loop mediated isothermal amplification (LAMP) testing for rapid diagnostic testing of COVID-19, along with an attached staff welfare changing and shower facility.

Other notable developments include our new £350k acute respiratory care unit at Ipswich Hospital, which provides additional beds for patients suffering from COVID-19 or other respiratory illnesses. The development of a new £1.23m elective care ward called Waldringfield, and a £1m refurbishment of ophthalmology theatres also took place. Work on our new emergency department and urgent treatment centre at Ipswich Hospital is also well underway. These developments are just some examples of the huge investment programme taking place across our Trust.

We were delighted to welcome 650 colleagues who worked for community interest company Anglian Community Enterprise in July 2021. We are part of a collaboration of providers who now deliver community services in north east Essex. Community services across east Suffolk and north east Essex have been pivotal to our response to both the pandemic and to rising demand for healthcare.

I feel very proud of being part of this Trust and am very grateful to all our colleagues, volunteers and communities who make ESNEFT an extraordinary organisation. Thank you.

Helen Taylor
Chair

Performance report – overview

The performance report helps readers to assess how the directors performed in their duty to promote the success of the Trust. The report has been prepared in accordance with the relevant sections of the Companies Act 2006, as interpreted in the Government Financial Reporting Manual. We have also taken account of Monitor guidance and the Financial Reporting Council guidance on the strategic report (November 2015) to ensure that the report is fair, balanced, understandable, comprehensive but concise and forward-looking.

Chief executive's overview and plans for the year ahead

I continue to be in awe of the dedication and commitment of our colleagues and the resilience of the communities and patients we serve, who come together as one to overcome the significant challenges we face together.

It has been my privilege to work in the NHS for more than 40 years. I think we were in one of the most difficult places I can ever recall in early March this year (2022). Rising numbers of COVID-19 patients, significant staff sickness and high demand for healthcare across the board placed enormous pressure on the system.

This has been an exceptional year for our Trust and the NHS as a whole. Exceptionally challenging at times, but also exceptionally rewarding.

When we created our Trust, bringing together two hospitals and community services in east Suffolk almost four years ago now, we had a once in a lifetime opportunity to do things differently to make life better for the communities we serve. The landscape of the NHS changed dramatically at the same time with the introduction of integrated care systems, bringing everyone involved in health, social care, local government and voluntary organisations together to find ways of working together differently.

Our ambition to make a real impact for people in east Suffolk and north east Essex is becoming a reality as we all work to address inequalities, and together with all our partners and the communities we serve, make sure that all services are accessible and equitable. This has been a big focus of our work this year led by Chief Medical Officer Dr Angela Tillett. The progress we are making is remarkable, but we recognise we have a long way to go.

We know we need to be more than a service that people go to when they get ill, we need and want to be part of the community as an anchor institution. We are also finding new ways to work differently, such as investing in community foundations, local charities and the voluntary sector which bring major benefits to those who need our support the most. We are joined together by common purpose and share a commitment to truly address inequalities and bring equity.

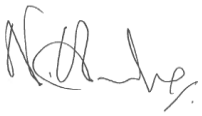
Our determination to reduce health inequalities involves facing a number of specific challenges. Many patients live in rural areas where the combination of poor transport links and lower-than-average car ownership makes appointments tougher to access. Tendring also has an average life expectancy significantly below national levels, particularly among men, with poor comparative outcomes from several types of cancer.

We are working hard to make sure that we make services accessible to all. For example, community diagnostic hubs backed by significant investment will give patients in our more remote locations better access to the very latest diagnostic technology and techniques. We are also developing a community diagnostic training academy in partnership with a further education provider to train people for future roles within the organisation.

Our programme of work is well informed by in-depth data. Studies carried out include looking at the reasons behind the correlation between ethnic groups and low appointment attendance level. This is particularly important within cancer care, since earlier diagnosis can make the difference between survival and a terminal case.

In the pages which follow, you will learn more about our work, achievements and objectives. I was very honoured to be asked to work at a national level at the Department of Health to lead the vaccination programme for 12 to 15-year olds from October 2021 to January 2022. My thanks to Deputy Chief Executive Neill Moloney for the excellent job he did in leading our Trust during this time.

I am delighted to be back.



Nick Hulme
Chief Executive

About us

History of the Trust

East Suffolk and North Essex NHS Foundation Trust was formed on 1 July 2018 through the merger of Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust.

The Trust also provides community health services and runs Aldeburgh, Clacton, Halstead, Harwich and Felixstowe community hospitals, as well as Bluebird Lodge near Ipswich.

The people we serve

We provide hospital and community health services to almost one million people living across a wide geographical area. We deliver care from two main hospitals in Colchester and Ipswich, six community hospitals and in patients' own homes. We also provide a range of specialised services, such as spinal surgery and prosthetics.

In 2021/22 we were one of the largest NHS organisations in the region and have an annual turnover of more than £856 million.

We are also one of the biggest employers in East Anglia, and employed 11,637 people on 31 March 2022.

Time Matters

At ESNEFT, our philosophy is that time matters to everyone. Too often, our current systems and ways of working add unnecessary stress and frustration. Across the Trust, we will concentrate on improving the things we do and removing those which do not work or cause time delays for our staff and patients throughout our day-to-day business.

Staff are being encouraged to make time matters principles integral to the way they work and continuously involve their teams in identifying issues and processes which are not working. As well as supporting their patients and colleagues, the approach aims to help them feel empowered to make changes within their service.

Statement of purpose and activities

Our vision and strategy

Our strategy was approved by our Board in April 2019 and runs until 2024. It was developed with our staff, partner organisations and representatives of the communities we serve, and sets out a clear and exciting direction for our services over the next five years.

Our ambition is to offer the best care and experience, and is supported by five strategic objectives which will guide planning and investment:

The document is aligned with national and local strategies and recognises that we are part of a complex system of health, care and wellbeing services and have key role to play in making sure that service users can receive joined-up care. At its heart is our philosophy that time matters, and our drive to reduce the unnecessary stress of navigating the system and free up time to focus on what matters most.

The significant challenges facing the health and care system as a whole will continue over the coming years. This is because of the continuing impact of the COVID-19 pandemic and our growing and ageing population, combined with shortages in supply of some groups of the workforce. To address this, we are adopting new ways of working and achieving higher levels of coordination with our health and care partners across the system. Developing our staff with new skills and introducing new roles is at the heart of this. Technology will also play a key role in making our services more accessible while helping us use information well. Innovation in treatments and diagnostic services are also needed to make sure that our services continue to be centres of excellence.

Our services

The Trust provides a range of patient services:

	2021/22
Outpatient attendances	979,321 (905,326 – medical virology COVID-19 tests)
Emergency department (A&E) patients (includes urgent treatment centre)	226,554 Main EDs and Colchester UTC (171,071 Main EDs only) 38,070 Clacton and Harwich UTCs 55,483 Colchester UTC 264,624 ESNEFT 93,553 urgent treatment centres only
Inpatient and day case admissions	Day cases: 87,519 Elective admissions: 10,761 Non-elective admissions: 90,924 Total overnight: 101,685
Babies born	6,872
Community hospital admissions	1,274 North East Essex Community Services 1,424 Ipswich and East Suffolk Community Services 2,698 ESNEFT
Community contacts	231,761 North East Essex Community Services 337,090 Ipswich and East Suffolk Community Services 568,851 ESNEFT

Key issues, opportunities and risks

As part of good governance, ESNEFT continues to identify issues, opportunities and risks that could affect the Trust in delivering our objectives to achieve future success and sustainability.

Key issues

- The population we serve is growing at one of the fastest rates in England. Favourably, some people are also living longer. Sadly, healthy life expectancy in Tendring has plateaued for men and women. These factors increase the number of people needing healthcare services.
- It is difficult to recruit staff across a range of key disciplines. In some teams, the mix of skills and staff roles could be developed further.
- Like many other trusts we are in underlying financial deficit, despite good progress in cost improvement over the last years.

- National standards for clinical service quality continue to rise and maintaining compliance is challenging in some areas.

Opportunities

- We have significant scale in many of our clinical services, with six specialties among the ten largest in England (by number of people treated).
- We have a range of new skills and roles being introduced into our services.
- We provide community services offering good integration of services. We continue (as part of an alliance of delivery partners) to provide community services within north east Essex.
- We operate in a system with a track record of strong partnership working with other health and care agencies, which is now being formalised as the integrated care system comes into being in July 2022. We are also continuing to look at further opportunities for partnership working to the benefit of patients.
- We have been allocated £69.3m of capital investment to ensure the sustainability of emergency and elective (planned) care services.

Risks

The causes of the risks and mitigating actions are described in more detail in the annual governance statement. In brief, the principal risks to the Trust's strategic objectives are:

- A failure to deliver the fundamental standards of care and reduce unwanted variation across all settings in the Trust, caused by inconsistent processes and practice, may lead to poorer patient experience and suboptimal clinical outcomes. This, in turn, may lead to increased regulatory scrutiny, reputational damage, financial cost through litigation, and potential negative impact on the recruitment and retention of staff and students. Oversight of the fundamental standards of care have been built in to the Trust's accountability framework and through performance monitoring. The Board is sighted on such metrics and improvements through an aggregate report (integrated report) at the Board.
- If the Trust does not continue to have robust oversight of quality outcomes and improvements through a clearly defined quality governance framework, this may lead to key issues and risks not being identified early, which will prevent the Trust reacting effectively and efficiently, thereby minimising the opportunity to avoid harm and poor patient and staff experience. This, in turn, may lead to increased regulatory scrutiny and associated issues. The Trust has a robust governance framework in place, which is reviewed to ensure that there is a clear ward to board and board to ward oversight of emerging issues and risks. Further assurance is provided via the Trust's Quality and Patient Safety Committee with onward reporting to the Board.
- If we do not engage the ESNEFT workforce with what the Trust is working to achieve and its values, there may be an impact on staff morale, productivity and potential for reputational damage. COVID-19 has enabled a positive change in staff engagement, with detail provided from page 86 onwards.
- If we do not establish systematic processes for identifying, measuring and delivering cost improvement opportunities and leveraging transformational change, then we will not deliver the cost improvement programme in the financial year or create long term opportunities for sustainability. This may lead to failure to deliver the control total, impact on cash flow and long-term sustainability as a going concern.

- Insufficient midwifery staffing may lead to unfilled shifts and potential for poor patient experience. The Board has approved £1.4m investment to establish additional midwifery posts which are being actively recruited to. Monitoring of maternity workforce occurs via the Trust's divisional accountability meetings and also via the Every Birth Every Day programme board, which also oversees all aspects of maternity service improvements.

- If we do not transform through strategy and its delivery then we will be unable to achieve long term sustainability leading to regulator intervention. The Trust has seen significant activity to transform our pathology services, investment in our infrastructure and new ways of working.

- If we do not have in place effective organisational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long-term sustainability as a going concern. The Trust has provided training resources for budget holders from Healthcare Financial Management Association building our financial management competencies.

- If we do not have a clear plan to support and develop our staff, improve recruitment and retention, grow our substantive workforce and strengthen staff engagement, leadership and culture across the Trust, then we will not achieve our ambitions. Significant work has been undertaken during 2021/22, including the development and implementation of the Trust's People Strategy, with oversight of the four key pillars by the People and Organisational Development Committee. Robust workforce metric development has occurred which is scrutinised as part of Board reporting via the integrated performance report.

- If we do not have services that meet the need of the local population during and post COVID-19, this may lead to prolonged waiting times which may give rise to suboptimal outcomes for patients. The Trust adapted ways of working and utilised partnerships with the independent sector to safeguard patient services (see operational performance section).

- If we do not have in place appropriate emergency preparedness, resilience and response (EPRR) to business disruption then there may be continued disruption to clinical and corporate services which may lead to patient care being suboptimal. The Trust EPRR policies were tested during COVID-19 and audited within year for effectiveness.

- If we are not able to respond effectively to potential IT disruption outage /incident, then there will be delays on clinical and corporate services operational and transformational delivery. The Trust continues to have in place business continuity plans for IT disruption and work towards being cyber secure.

- If we do not have agreed future models of care or the capital investment to deliver the ESNEFT estates strategy to provide a safe, compliant and functionally suitable environment for patients, visitors and staff this will impact our ability to deliver the overall trust wide strategy and integrated care system objectives. The Trust has seen significant investment in estate development and infrastructure schemes, with details on page 23.

- If investment to support IT strategy delivery is not available then there could be delay to the delivery of enabling programmes of work to support the delivery of the Trust's strategy.

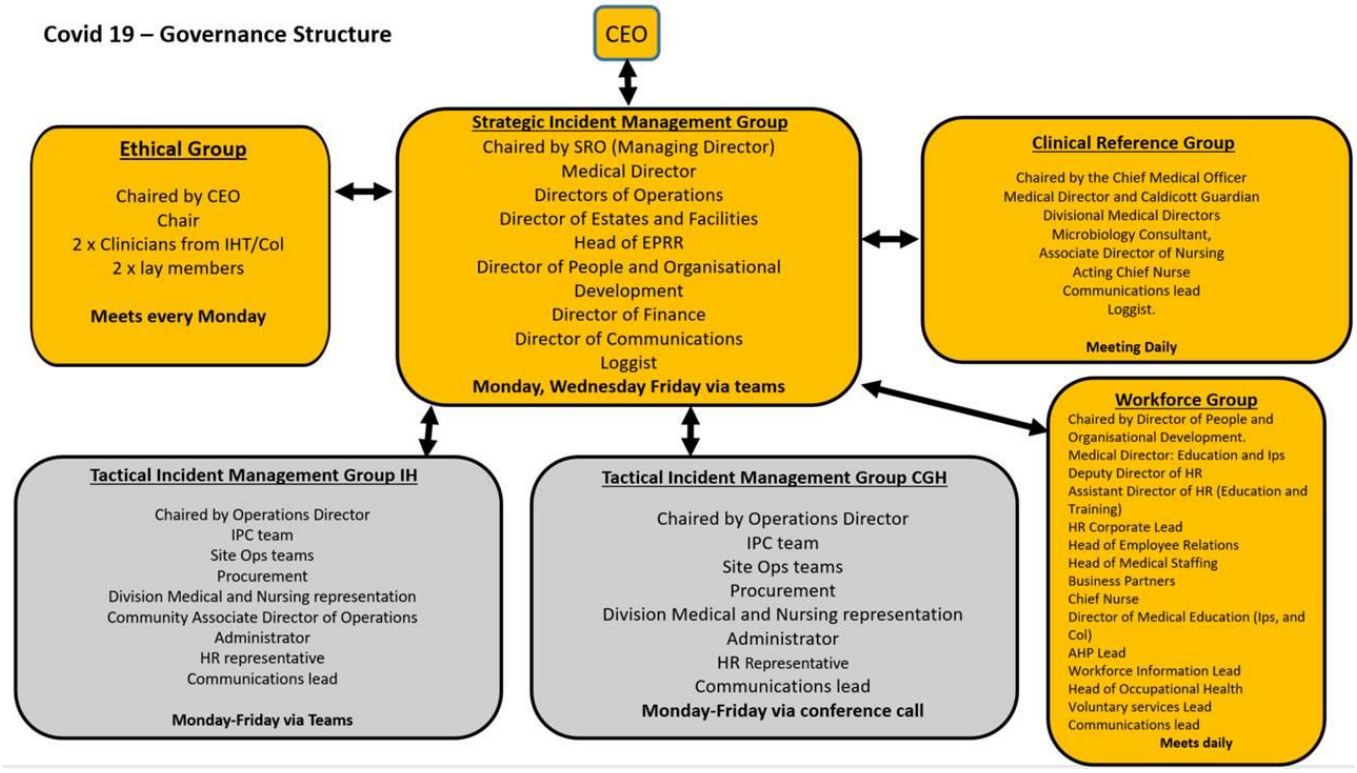
Emergent risks

- Responding to changes arising from the potential reconfiguration of integrated care system boundaries resulting in uncertainty of the commissioning landscape affecting long term service planning and financial stability.

COVID-19

We continued to respond to the ongoing COVID-19 pandemic throughout 2021/22 and maintained our major incident command and control governance structure, which included:

- **A strategic incident management team (SIMT)** – providing strategic leadership, direction and coordination for ESNEFT's response to COVID-19 and identify strategic and operational objectives to ensure preparedness and effective risk manage for the duration of the incident. This group was chaired by the deputy chief executive.
- **Tactical incident management groups** – providing operational coordination for ESNEFT's response to COVID-19 and deploying the decisions made at the SIMT.
- **Strategic workforce group** – providing effective advice and preparedness on coordination and prioritisation of training, health and wellbeing and the attendance of staff and volunteers.
- **Clinical reference group** –.reviewing guidance issued by Public Health England and other national bodies in relation to COVID-19 on behalf of the SIMT.
- **Clinical ethics and advisory group** – advisory function to ensure consideration is given to the wider ethical implications of the decisions made around PPE, resuscitation guidance and principles for allocation of resources.



Treating our patients more quickly – elective recovery programme

Much of our focus throughout this year has been on treating our patients more quickly. Our integrated care system – Suffolk and North Essex ICS – was one of the pilot sites to receive additional funding, in our case £10 million, for our elective recovery programme.

There were three main strands to our approach:

- Changing the way we work – transformation
- Productivity – are we using all of our resources in the best way possible?
- What 'additional' things can we do?

Changing the way we work included:

- Working with the NHS national team on outpatient transformation including asking patients if they want to have a follow-up appointment to get in touch by giving them a blue card, giving advice and guidance, risk assessing patients before inviting for follow-up appointments and expanding the use of virtual clinics and good news letters.
- Streamlining the way we run pre-operative assessment clinics so that it is easier for patients. This work includes looking at booking pathways, completing data analysis and defining the current pathways.
- Introducing a system for virtual pre-operative assessment.
- Using elective recovery funding to tackle health inequalities and working to take services into our most deprived communities.

Our productivity work included:

- Improving our pathways for high volume and low complex procedures (such as bunions for example) using the 29 national 'Get It Right First Time' pathways (GIRFT) to make sure we are following national best practice.
- Taking part in a national programme to introduce system-wide seamless care for patients in cardiology, eye care and orthopaedic services.
- Improving theatre productivity.

Our additional work included:

- Arranging additional and extended clinics and theatre lists.
- Holding super weekends to increase outpatients' throughput.
- Opening a Vanguard theatre unit (mobile theatre) at the Ipswich Hospital site to provide additional theatre capacity for West Suffolk Hospital and nine months for ESNEFT.
- Working in partnership with the independent sector.
- Using an external organisation to 'insource' care within our services.
- Creating an expanded bed base by turning a non-clinical area into a clinical space.

Some key achievements included:

- In April 2021, 40% of our waiting list was not clinically prioritised. By the end of March 2022, this sat at 5%.
- We are forecasting that no patients will be waiting over 104 weeks by the end of June 2022. The exception to this is oral and maxillofacial surgery patients, which we are addressing.

Going concern disclosure

These accounts have been prepared on a going concern basis. In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern.

In making this assessment, management has taken into account the Trust's income and expenditure plan for 2022/23, which is to break even, and the current cash position of the Trust. The Trust's current

cash plan for 2022/23 is not reliant on Department of Health and Social Care (DHSC) funding for cash financing with a forecast cash balance of £67m at 31 March 2023. The Board concludes there to be no material uncertainty around going concern for the period to 30 June 2023.

In light of these considerations and having made appropriate enquiries, the directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As directed by the Department of Health and Social Care Group Accounting Manual 2021/22, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future in the public sector. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Performance report – analysis

This section provides more detail about the Trust's performance and information on our most important performance metrics, including finance, activity, quality and our future plans. It also includes plans relating to regulatory compliance.

Care Quality Commission (CQC) registration

East Suffolk and North Essex NHS Foundation Trust has unconditional registration with the Care Quality Commission with no enforcement action. In line with the Care Quality Commission's inspection framework, the last inspection of our core services, use of resources and well-led took place in 2019/20.

In February 2021, the CQC inspected maternity services at both Colchester and Ipswich hospitals and recorded a rating of 'requires improvement'.

There have been no restrictions placed on the ESNEFT CQC registration.

NHSI enforcement undertakings

NHS Improvement (NHSI) implemented the Single Oversight Framework (SOF) in January 2016. The framework has 35 metrics across the domains of

1. Quality: Safe, effective and caring
2. Operational performance
3. Organisational health and
4. Finance and use of resources

NHSE/I used a series of "triggers" to identify potential concerns and inform provider segmentation. There were four segments ranging from maximum provider autonomy (segment one) to special measures (segment four). The NHSE/I single oversight framework included five constitutional standards:

1. A&E
2. RTT 18-weeks
3. All cancer 62 day waits
4. 62 day waits from screening service referral
5. Diagnostic six week waits

Following a consultation period, in June 2021 NHSE/I published updated oversight arrangements: the System Oversight Framework 2021/22. The proposals are designed to strengthen the system-led delivery of integrated care. They include a framework based on five national themes (not CQC domains, but broadly aligned to these) that reflect the ambitions of the NHS Long Term Plan and apply across providers, commissioners and ICSs:

1. Quality of care, access and outcomes
2. Preventing ill health and reducing inequalities
3. People
4. Finance and use of resources and
5. Leadership and capability

There is also a sixth theme based on local strategic priorities.

However, following a review by the Trust shared with the Board previously, further guidance is awaited on the 'data definition' and detail of many of the indicators included in the System Oversight Framework. This has been highlighted to East of England NHSE/I and work is ongoing to understand the reporting requirements for 2022/23. On this basis, the Trust continues to shows performance for each of the SOF metrics along with relevant trend information (where available). Some indicators have been removed where the measure is no longer used (such as the staff friends and family test), or where the Trust has specifically been instructed by NHSE/I to stop reporting (such as caesarean section targets).

Following consideration by the NHSE/I regional support group, it has been agreed that Suffolk and North East Essex ICS should be placed into SOF segment two, which is defined as an ICS on a development journey, demonstrating many of the characteristics of an effective, self-standing ICS. The regional team will work with the Trust to access flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (e.g. GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via the regional improvement hubs.

Financial outlook

The Trust's accounts for 2021/22 have recorded a deficit of £5.6 million (excluding the consolidation of charitable funds). This includes a significant impairment of assets of £12.6 million. NHSI/E measure the Trust's financial performance after adjusting for certain items, such as impairments and donated income. On this measure, the Trust delivered a surplus of £8.2m.

The Trust has developed a draft plan for 2022/23 which was submitted to NHSI/E on 17 March. This draft plan was constructed in line with current national NHS planning guidance and forecasts the delivery of a break even position. However, the prevailing highly volatile national and international economic environment may prejudice the Trust's ability to deliver this forecast and may result in a change to national planning assumptions. There are ongoing discussions with national and regional colleagues to resolve this situation.

To simplify processes and reduce the number of transactions during the COVID-19 pandemic, a temporary financial framework was introduced in 2020/21 which included moving to a nationally determined monthly 'block contract' payment. These arrangements continued into 2021/22.

NHSI/E is planning to move away from these temporary arrangements and issue longer term financial allocations for the period from 2022/23 to 2024/25. These allocations are expected in the coming months and will establish some longer term financial certainty for the Trust. As a consequence, The Trust will review its medium to long term financial planning upon release of these allocations.

Cost improvement programme

It is our ambition to deliver a financial break even position in 2022/23. To achieve this, it will be necessary to deliver a cost improvement saving of £27.6m. This is approximately 3.1% of the Trust's expenditure baseline (excluding pass-through costs). The Trust is developing plans to achieve these cost improvements.

Cash funding

The Trust is not planning to be reliant on Department of Health funding for cash financing.

NHS Improvement will review our plans to ensure that financial support is provided only for the necessary costs of running a safe organisation. Discretionary spending and investments will be reviewed as part of the conditions of accessing funding from the Department of Health.

Long term planning

The requirements of the NHS Long Term Plan, which was published in January 2019, set out the need for trusts which are in deficit to be back in balance by 2023/24. To help us achieve this, the Trust developed a long term financial plan. The outbreak of COVID-19 then impacted on the delivery and trajectory of this plan.

The COVID-19 pandemic necessitated the implementation of simplified finance and contracting arrangements that supported systems to dedicate maximum focus on responding to immediate operational challenges. As service restoration now begins, the financial and contracting frameworks have evolved again to enable systems to take the appropriate financial decisions for their populations.

The future NHS financial framework will continue to support system collaboration building on the progress made by integrated care systems as such systems will continue to be the key unit for the purposes of allocations and financial planning.

The key elements of the 2022/23 financial framework are:

- Agreeing a 'glidepath' from the current system revenue envelopes to 'fair shares' allocations. In addition to a general efficiency requirement, NHSE/I will apply a 'convergence adjustment' to bring systems gradually towards their fair share of NHS resources.
- The Health and Care Bill sets the requirement that integrated care boards (ICB) and trusts are held collectively responsible for their use of revenue and capital resources. Each ICB and its partner trust(s) will have a financial objective to deliver a financially balanced system, namely a duty to breakeven.
- There will be additional revenue and capital funding to support systems to tackle the elective backlog and deliver the NHS Long Term Plan.
- There will be increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.

In line with this guidance NHSE/I has issued financial allocations for 2022/23 and is planning to issue longer term financial allocations for 2023/24 and 2024/25. These allocations are expected in the coming months and the Trust, with its ICS partners, will review its medium to long term financial planning upon release of these allocations.

Financial performance

The Trust's accounts for 2021/22 have recorded a deficit of £5.6m (excluding the consolidation of charitable funds). This includes a significant impairment of assets of £12.6m. NHSI/E measure the Trust's financial performance after adjusting for certain items, such as impairments and donated income. On this measure, the Trust delivered a surplus of £8.2m.

	2021/22 £m	2020/21 £m
Operating income	961.0	856.5
Operating costs	(956.9)	(874.9)
Operating deficit from continuing operations	**4.1**	**8.6**
Non-operating costs	(9.7)	(9.5)
Surplus/(deficit) for the year before gains arising from transfers by absorption	**(9.7)**	**(0.9)**
Gains arising from transfers by absorption	0	0.3
Surplus/(deficit) for the year	**(5.6)**	**(0.6)**

Consolidated accounts

The Trust has not consolidated the activities of the Colchester & Ipswich Hospitals Charity, whose activities are not considered to be material.

Operational service standards

Emergency department (A&E) four-hour standard

The Trust recorded a performance of 80.9% against the national standard of 95%.

National access standards

Our performance against the challenging national access standards between 1 April 2021 and 31 March 2022 was:

	Standard	Performance
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	76.8%
Two-week wait for symptomatic breast patients (cancer not initially suspected)	93%	34.1%
All cancers: 62-day wait for the first treatment from national screening service referral	90%	70.1%
All cancers: 62-day wait for the first treatment from urgent GP referral to treatment	85%	76.8%
All cancers: 31-day wait from diagnosis to first treatment	96%	94.2%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days. **Reporting suspended due to COVID-19 until Q3 2021/22**	100%	82.0%
Percentage of patients on an incomplete pathway with a maximum of 18 weeks waiting time	92%	67.0%
MRSA	0	4
Incidence of Clostridium difficile infection	18	97

Data sources: cancer national return, RTT national return, Accountability Framework

It has continued to be a very unusual year for delivery against these core services as we balanced caring for COVID-19 patients with managing the backlog of patients waiting for elective care and a significant increase in the numbers of referrals, particularly for cancer services.

We have seen an increase of around 27% on average in the volume of patients we are now treating in cancer services. Our Trust is one of the top three centres in the country in terms of numbers of cancer treatments we are carrying out. This increase in volume and the drive to treat our patients more quickly through the elective recovery programme has led to a drop in performance in some areas, such as the two-week waiting time standard.

Greater access to diagnostic testing with the development of the Clacton Community Diagnostic Centre has meant that we have been able to reduce waiting times for medical imaging for patients with cancer. Despite the challenge of managing COVID-19 patients in emergency and urgent care, we continued to be innovative and dynamic in developing new services.

At Colchester Hospital, a new acute medicine same day emergency care (AMSDEC) unit and a new frailty unit were developed and opened during the year. A new surgical assessment centre was also developed and opened in early April 2022. We also opened a new temporary urgent treatment centre at Ipswich Hospital.

Much of our focus has been on partnerships, especially with the East of England Ambulance Service NHS Trust. REACT (Rapid Emergency Assessment and Care Team), which is made up of nurses, therapists, assistant practitioners and social care colleagues, has been immensely successful in working with ambulance colleagues to avoid admissions to hospitals.

Community services in both east Suffolk and north east Essex have played a pivotal role in how we have and continue to manage increased demand for healthcare and the increasing acuity of our patients.

Our performance against the national access standards like many other Trusts was challenging.

We have made significant progress with our elective recovery programme, in particular seeing the patients who have waited the longest and having no one waiting more than 104 weeks by the end of July 2022 without a date to come in for treatment (with the exception of patient choice).

For much of the year 2020 to 2021 we were managing caring for patients with COVID-19 with a major programme of elective recovery. We also had significant levels of staff sickness due to COVID-19.

Referrals for suspected cancer care have dramatically increased and we are working with all of our system partners to understand how we can best manage this increase.

A major change programme to improve emergency and urgent care is underway at both Ipswich and Colchester Hospitals to improve the way we care for patients and achieve the national access standards.

Capital estate development and infrastructure schemes

The estates capital development team has continued to focus on the Trust's response to the COVID-19 pandemic this year, while also completing a number of significant capital development estates schemes to support clinical service delivery. Our clinical services develop and change constantly, and the built environment needs to keep pace.

During 2021/22, we are proud to have successfully delivered the following significant capital development projects alongside others which are currently in construction:

- New £5.3m molecular laboratory at Ipswich Hospital. This permanent facility for COVID-19 testing and other molecular diagnostic services was established in the last year.
- New £8.9m combined interventional radiology and cardiac angiography (IRCA) unit at Colchester Hospital for the treatment of patients with peripheral vascular disease and other major diseases like aortic aneurysms. The unit means that patients can be treated without an open operation by using modern techniques of interventional radiology.
- Completion of the new £960k pathology laboratory at Ipswich Hospital for rapid loop mediated isothermal amplification (LAMP) testing for COVID-19. The development includes a staff welfare changing and shower facility.
- Replacement £1.2m oxygen vacuum insulated evaporator (VIE) tanks and associated oxygen pipework at Ipswich and Colchester hospitals to increase capacity during the COVID-19 pandemic response and to assist with future capital development projects and clinical activity. The old VIEs have been removed and the new tanks are now in use.
- New £350k acute respiratory care unit at Ipswich Hospital providing additional respiratory beds for patients suffering from COVID-19 or other respiratory illnesses.
- £1.23m redevelopment of Waldringfield Ward for elective care at Ipswich.
- £2.84m installation and commissioning of Alton block, which is a modular office block at Ipswich which has been introduced to increase the amount of clinical space available.
- £1m refurbishment of the ophthalmology theatres block.

During the year, work has also taken place on the following capital development schemes, which will either conclude or construction will begin during 2022/23:

- New £23.1m emergency department/ urgent treatment centre build at Ipswich Hospital, which also includes a new main entrance, retail units and surgical admissions unit
- £7.541m reconfiguration of Colchester emergency care pathway stream one
- New £5.27m combined breast care centre at Ipswich

- New £9.16m community diagnostic hub at Clacton
- New £49m Dame Clare Marx Building at Colchester
- £6.9m redevelopment of the children's department at Ipswich
- £2.3m refurbishment for ophthalmology outpatients at Ipswich
- Planning for a new entrance into Colchester Hospital from Northern Approach
- Planning for car park deck two at Colchester
- Transfer of three community sites from NHS Property Services to ESNEFT

Research and development/ innovation

We are fully committed to developing and supporting research which improves the quality and experience of care for local people, as well as making our contribution to wider health improvements. It is central to secure our future as a leading clinical research centre for specialist care in the UK.

We know that patients who are cared for in a research active environment have better outcomes. As such, we aim to increase our research portfolio year on year to be able to offer our patients the very best treatments, medicines and services. We continue to work with many different organisations national and internationally so that our patients can access new medicines, devices or treatments as part of clinical trials.

During 2021/22, ESNEFT was able to deliver relevant research benefits to 5,335 patients on 98 clinical trials, including trials to reduced symptoms, increase survival times and improved quality of life. Some of our patients were the first to be recruited in Europe.

We actively seek to attract high quality research staff to help develop our research portfolio. The number of staff involved within our research and development fixed term workforce is 68, while 149 principal investigators were involved in leading research studies across our sites. We empower our research teams to champion research, ensuring it is visible and impactful for both patients and staff.

The outbreak of COVID-19 and the associated restrictions had a major impact on our research portfolio, with the majority of our active research studies paused in March 2020. We have now restarted all studies which were paused which the sponsor has restarted nationally. We continued to support nine COVID-19 NIHR urgent public health studies to help the NHS better understand the range of symptoms caused by the virus and the most effective treatments. We were also involved in 89 non-COVID-19 recruiting clinical research studies. All 98 were delivered across 28 specialities.

Our Trust is a member of the NIHR Clinical Research Network: Eastern (CRNE), which is responsible for effectively delivering NIHR research in the east of England. The majority of funding for our research activity flows through CRNE, with just over £1.7m allocated for research staff and supporting activity during 2021/22.

As well as increasing the opportunities for our patients to take part in NIHR portfolio research studies, the Trust has an ambitious strategy for research and development which includes hosting and developing our own research for the benefit of our local community. We are continuing to build our team to deliver that ambition. The team now includes two allied health professional clinical academic research leads, while a joint clinical academic post with the University of Suffolk is in place. We have developed similar posts with local universities for 2022/23.

Research governance

All research is delivered in accordance with the UK Policy Framework for Health and Social Care Research (2017). This sets out the research governance principals which protect and promote the interests of patients, service users and the public in health and social care by describing ethical conduct and proportionate assurance based management of health and social care research.

We ensure that all of our research has undergone robust governance, and Trust assurance is required before any research can start at the organisation. All studies on the NIHR portfolio have been through quality assurance processes to ensure compliance with good practice.

Staff undertaking research activity should be trained in International Conference Harmonisation – Good Clinical Practice (ICH-GCP), which is valid for two years, to ensure best practice is maintained.

Quality improvement

We recognise that staff who are closest to an issue are often the best placed to address it, and quality improvement (QI) is designed to facilitate that process. At ESNEFT, the QI team has developed a strategy designed to embed an organisational improvement mindset. It focuses on:

During the year, the team has focused on:

- Building QI capability in staff by teaching them QI skills and coaching them so they have access to the support required to understand problems and address change:
    - we have now trained 255 staff at bronze level QI and 184 staff at silver level
    - conversion from silver level QI training to a registered QI project is now 34%, with a further 26% in planning phases.

- Increasing QI capacity of skilled QI leaders across the Trust and embedding quality improvement processes into our services so that quality improvement becomes the 'way we work':
    - we have a 'QI champion' job description which can be built into existing/ developing roles or service level job descriptions, with staff now delivering these roles within the Trust
    - we are aligning our central and local audit and improvement work more closely to ensure a strategic approach and that we are making best use of resource to drive improvements for our patients.

- Developing an ethos of continuous improvement so that projects are not only delivered as individual examples of improvement but ensure sustainability and spread:
    - 41% of our registered projects now go to completion with measurable results of improvement
    - all projects are measured against a 'return on investment' model to evidence the impact of QI at ESNEFT.

Innovation

Activity to support innovation within the Trust saw significant progress in a number of areas, including:

- **Robotic surgery:** Following initial investment in 2019/20, the Trust has embarked on a programme of progressing the use of robotic surgery across several disciplines. As a consequence, we are building a knowledge base and specific expertise on these forms of surgery while understanding more about the direction that these technologies are travelling in. As such, ESNEFT in a good position to drive innovation, research and education into these fields.

  We have invested in our second and third Da Vinci robotic systems for abdominopelvic surgery, thereby allowing for an expansion of both the volume and range of procedures undertaken at the Trust. The technology will be used across both hospital sites to support procedures across general surgery, urology and obstetrics and gynaecology. Following a very successful first year of using the initial Da Vinci system which has seen significant benefits to patients, ESNEFT surgeons have become proficient in its use, with one of its first robotic surgeons becoming a proctor for the manufacturer.

Similarly, in knee surgery, the Trust currently has two robotic systems and is considering further investment in robotic technology for both knee and hip replacement surgery. This has put our clinicians in a good position with industry to both test and drive potential innovation within the sector.

On the back of the above investments, we are establishing the Institute of Excellence in Robotic Surgery in collaboration with Anglia Ruskin University (ARU) and industry partners. This will advance the use of these technologies to benefit both the Trust and ultimately our patients. The institute will bring together a combination of the resources, knowledge base and expertise drawn from both institutions. These would include but not be limited to the ICENI Centre at Colchester Hospital, which is an internationally renowned and Royal College of Surgeons-accredited centre for advanced surgical techniques, and ARU's School of Medicine.

The focus of activity will encompass a range of education and training, research, innovation and technology development. This will take place in disciplines such as simulation, orthopaedic and abdominopelvic surgery, biomechanical engineering, computing/robotics, psychology/ neuroscience, ethical considerations, and the outcomes and benefits of robotic surgery.

- **Digital histopathology:** Through collaboration with Norfolk and Norwich University Hospitals (NNUH) and West Suffolk NHS Foundation Trust (WSFT), we have secured £1.4m of capital investment from the national programme to develop a regional digital reporting system within histopathology during 2022/23.

  The benefits to our patients and to the Trust include:

  - Faster reporting times and removing the need to outsource samples, improving our turnaround times for diagnosis and enabling productivity to increase by 12%.
  - Faster second opinions by enabling digital images to be viewed instantly by colleagues at NNUH and WSFT.
  - Improved quality of diagnoses through more accurate accounting and measurements of samples.
  - Improved quality of meetings due to images being more readily available for MDTs in a timely fashion.
  - Enabling the introduction of artificial intelligence (AI) technologies which are thought to provide efficiency gains of between 20 and 40%.
  - Improved staff retention and staff recruitment.
  - Reduction in outsourcing and recruitment of locums.

- **The introduction of artificial intelligence (AI) in clinical settings:** This includes:

  - **E-stroke:** We worked with Oxford-based Brainomix to introduce E-stroke software in August to improve stroke care. E-stroke uses AI to analyse images of the brain and blood vessels, and automatically flags blockages to clinicians to help guide treatment decisions, potentially helping patients receive life-saving treatment more quickly. The technology also allows scans to be securely and quickly shared 24/7 with colleagues at specialist centres to gain a second opinion to support fast diagnosis and treatment. It has been funded for three years by an award from NHSX.

  - **Heartflow:** Introduced through the national Medtech Funding Mandate Programme, Heartflow will provide a non-invasive cardiac test which gives a detailed view of a patient's coronary arteries. It enables physicians to create more effective treatment plans for patients with coronary artery disease by creating a digital 3D model of the arteries via a non-invasive CT angiogram. Computer algorithms are used to solve millions of complex equations which assess the impact that a blockage has on blood flow. We estimate that the technology will help around 90 patients in 2022/23.

- **Qure.AI:** Funded through the SBRI Healthcare Cancer Programme, this AI tool supports the interpretation of chest x-rays and is believed to be able to detect multiple abnormal findings in less than one minute. Scans can be separated between abnormal and normal scans interpreting abnormalities in the lungs quickly, in turn aiding diagnosis and leading to better outcomes. The funding will allow for the evaluation of the technology "in the field," with ESNEFT being one of a number of trusts taking part.

- **C2-AI:** C2-AI uses AI to support elective patient waiting list management, enabling the prioritisation of patients and aiding capacity planning processes to help reduce risk. With the support of the Eastern Academic Health and Science Network, ESNEFT is helping to evaluate the benefits of the technology and what impact it might have on our waiting lists.

- **Apprenticeships:** The Trust has introduced a package of measures to achieve a step change in its use of apprenticeships and subsequent utilisation of its apprenticeship levy. We have:

  - received formal approval from the Education and Skills Funding Agency to become an employer provider of apprenticeship training for our own staff, and are establishing team to deliver this work
  - agreed partnerships with both of our main further education colleges, Colchester Institute and Suffolk New College, which will generate a pipeline of well-prepared future employees through a combination of work placement and mentoring schemes
  - established a training academy at Clacton Hospital, in partnership with Colchester Institute, to support local people into jobs at the new community diagnostic centre
  - put workforce plans in place which properly recognise apprenticeships as an effective way of supporting new entrants into the ESNEFT workforce in addition to the upskilling of existing staff

  These measures will provide a more strategic Trust-wide approach to the use of apprenticeships which will:

  - increase the number of apprenticeships within ESNEFT to around 500 per year
  - use apprenticeships to improve career development pathways
  - increase our offering to entry level staff to undertake an apprenticeship and improve the retention and recruitment of entry level staff groups
  - increase the breadth of apprenticeship opportunities available to staff regardless of job type, banding or location
  - use apprenticeships as a vehicle through which the Trust can enhance its leadership and management capabilities
  - make full use of the Trust's annual apprenticeship levy and recover as much of the apprenticeship levy already paid into the ESNEFT digital apprenticeship account as possible
  - satisfy our public sector apprenticeship target of a minimum of 2.3% of our workforce undertaking apprenticeships each year

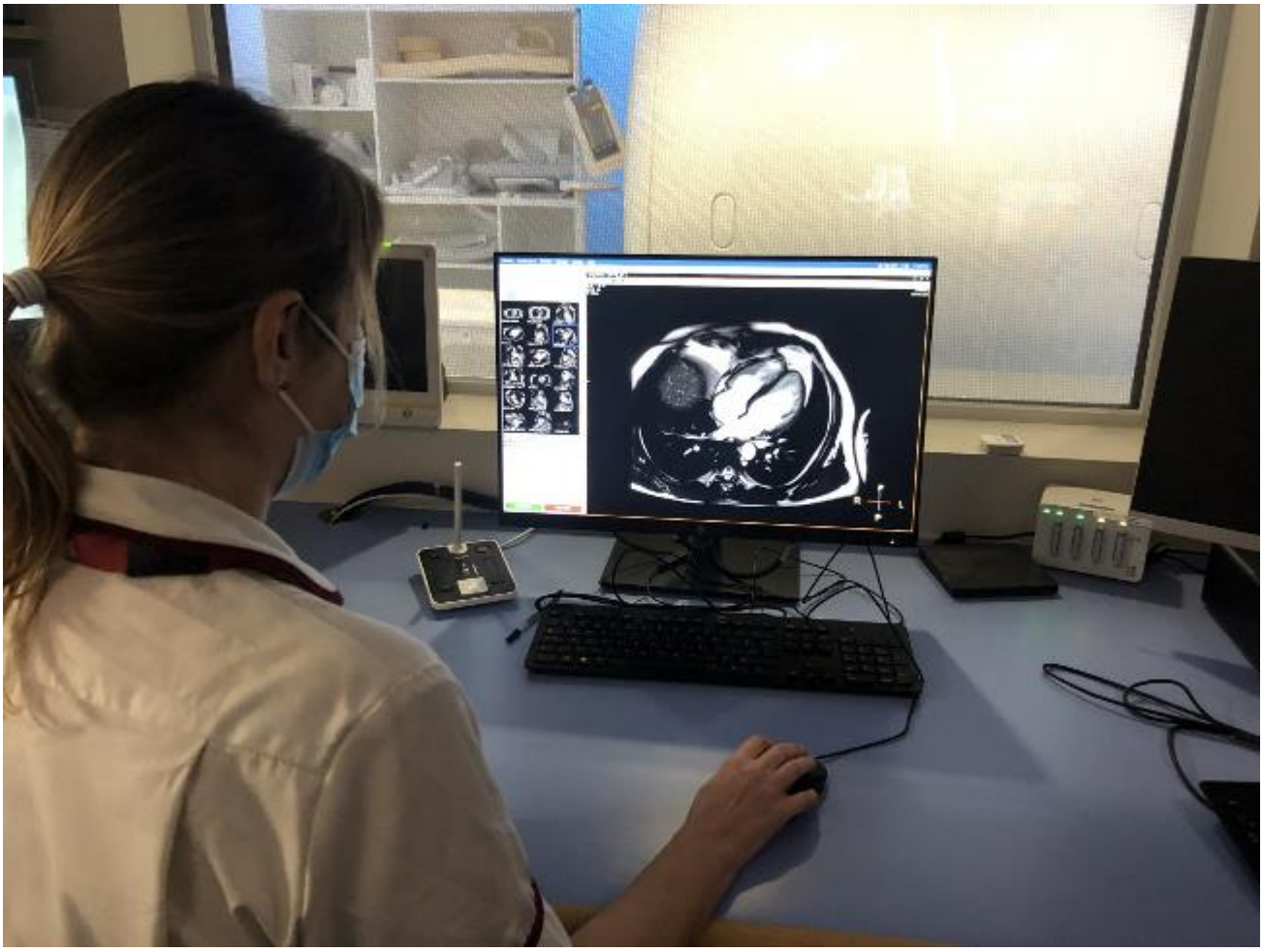
- **Advanced clinical skills and simulation:** During 2021/22, investment has taken place in several projects which will enable ESNEFT to remain at the leading edge in training simulation. This includes:

  - **Virtual reality (VR)/ augmented reality (AR) training simulation:** Approximately £1.5m has been invested in a new VR/AR simulation suite at the ICENI Centre which has secured the latest simulators for robotic surgery, ophthalmology, obstetrics and gynaecology, endoscopy and endovascular training. A new curriculum is being developed to gain full benefit from the technology in 2022/23, and is being supported by an ICENI Centre international fellow in simulation, who will be recruited to drive the curriculum forward and undertake research on its impact.

- **East Anglia Simulation Centre (EASC) at Ipswich Hospital:** Further investment has been made into the EASC at Ipswich Hospital to sustain and enhance the training it delivers. £0.25m of investment has been spent replacing out-of-date equipment and bringing in new technology that which help to develop a more multidisciplinary approach to learning.

- **Proposed new Faculty of Education and Innovation Centre at Colchester Hospital:** Following consultation with colleagues and local stakeholders during 2021, a planning application is being prepared for a new 2,957.93 sqm (31,840 sq ft) Faculty of Education and Innovation Centre at Colchester Hospital.

  The centre will offer state-of-the-art training facilities, including cadaveric, VR simulation, a 120-seat lecture theatre and flexible spaces for scenario-based multidisciplinary training, and will help us deliver the rise in apprenticeships we are anticipating will take place at ESNEFT in future years. It is also expected to provide innovation space, potentially supporting early stage medical/care technology companies with business incubation facilities. A demand study for these facilities is expected to be completed in April 2022, with a decision on the planning application expected in August.



Environmental sustainability

As a publicly-funded organisation and good corporate citizen, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health in both the immediate and long term, even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We have developed a three-year green plan which identifies the ways in which the Trust's activities impact on the environment. In addition, we have recently published our updated net zero plan, which has been adapted to accommodate the new national commitment of reaching NHS net zero by 2040. This follows the publication of the 'Delivering a Net Zero National Health Service' report.

Sustainability strategy

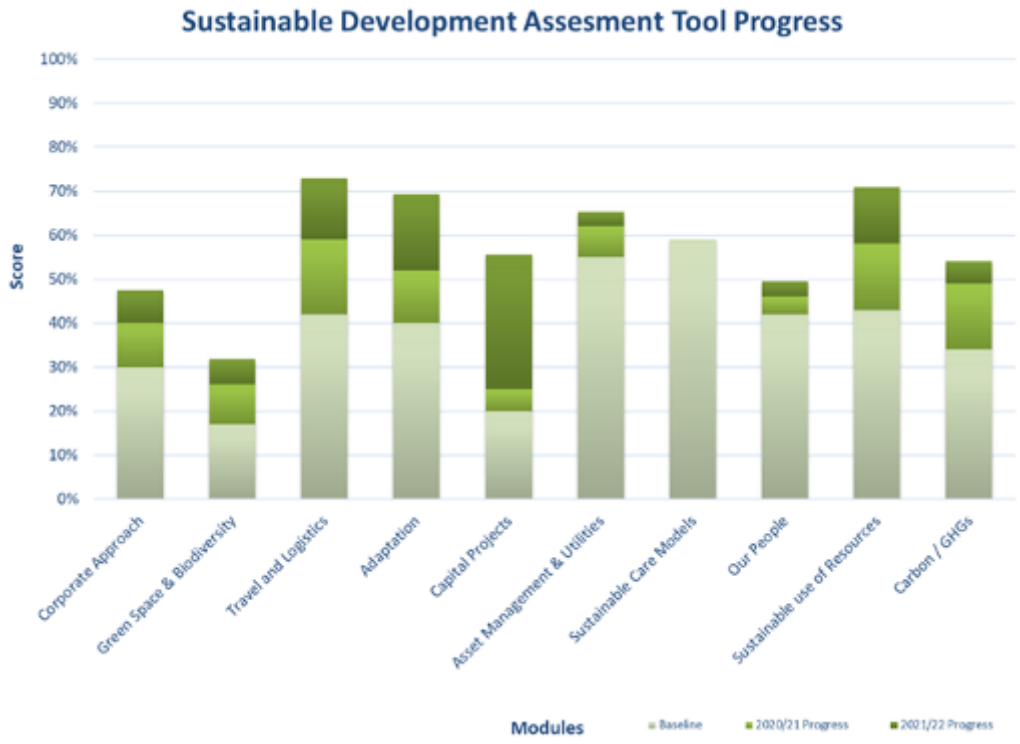
Our sustainability mission statement is **to become a leader in sustainable healthcare,** aiming to reduce 80% of the carbon emissions we directly control by 2028-2032 before reaching net zero by 2040.

Policies

In order to embed sustainability within our business it is important to explain the sustainability features in our processes and procedures. One of the ways in which the Trust embeds sustainability is through our green plan and net zero plan.

Our impact on corporate social responsibility has historically been measured using the sustainable development assessment tool (SDAT) tool. Although this tool has now been removed from service, we have continued to track our progress with a local version. Since our green plan was published in 2020, we have advanced from a score of 38% to 57%, signifying that good progress has been made so far.

Our SDAT progress for 2021/22 is shown in the table below:



We acknowledge our responsibility towards creating a sustainable future, and work towards that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

ESNEFT contributes to the following sustainable development goals:

Partnerships and engagement

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be made in part through contracting mechanisms.

We have continued to be active members of Colchester Travel Plan Club and are active members of national performance advisory groups for car parking, sustainable travel and waste.

The energy and sustainability team continue to use Twitter (@ESNEFT_EFM), and has improved its presence on the intranet and the Trust's website by introducing a dedicated page which includes a link to the green plan.

We will continue to seek to improve our communications to staff in regards to saving energy whilst at work while also keeping them updated on our projects.

Organisation performance

Energy

We have carried out a number of activities over the past 12 months. Since April 2021, the Trust has switched to purchasing REGO-backed 100% renewable electricity. We have also installed our first solar panels at Ipswich Hospital on the new pathology building.

We have continued to replace fluorescent lighting with LED lighting at both Ipswich and Colchester hospitals, with this work continuing into 2022/23.

Feasibility studies have also begun to investigate our route towards the carbon net zero ambition, with a particular focus on moving away from our dependence on natural gas and the use of emerging technologies.

Energy used

Resource		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Gas	Use (kWh)	34,188,424	30,808,829	35,334,914	34,605,401	33,995,271	32,792,345	33,648,340	34,644,553
	tCO_2e	7,173	6,448	7,385	7,207	6,255	6,031	6,188	6,371
Oil	Use (kWh)	1,161,491	644,657	1,406,948	474,999	334,617	126,055	108,965	127,120
	tCO_2e	372	206	446	109	93	32	29	34
Electricity	Use (kWh)	14,707,497	22,006,469	29,353,175	27,598,731	28,549,523	28,248,752	28,539,262	0
	tCO_2e	9,109	12,652	15,170	12,301	8,770	7,833	7,238	0
Green electricity	Use (kWh)	13,345,551	7,078,886	441,766	1,267,547	200,774	30,352	27,052	20,965 (PV) 32,175,148 (Grid)
	tCO_2e	8,265	4,070	0	0	0	0	0	6,832
Total energy CO_2e		24,919	23,375	23,000	19,618	15,118	13,896	13,455	13,237
Total energy spend		£ -	£ -	£ -	£ -	£ -	£ -	£ -	-

Renewable energy

Colchester Hospital has two sets of solar photovoltaic (PV) panels which generated a total of 20,965 kWh during 2021/22, reducing the amount of grid-supplied electricity used by the Trust and generating income. This figure continues to be lower than previous years due to works on the IRCA building.

Clinical waste is incinerated on site at Ipswich Hospital and the heat recovered is used to provide heating and hot water, which means much less gas is used than at other equivalent hospitals. This reduces our carbon emissions by more than 3,500 tonnes. Plans are underway to make use of this heat during the summer, when it is normally discharged into the atmosphere, to provide cooling in place of electric chillers.

Travel

We have completed a healthy transport plan as part of our travel policy and are keeping it under review.

We promote active travel to our staff, patients and public to improve local air quality and the health of our community. We have signed a three-year deal with Mobilityways to support us to reduce single occupancy journeys, and continued to offer subsidies on bus and rail fares during the year.

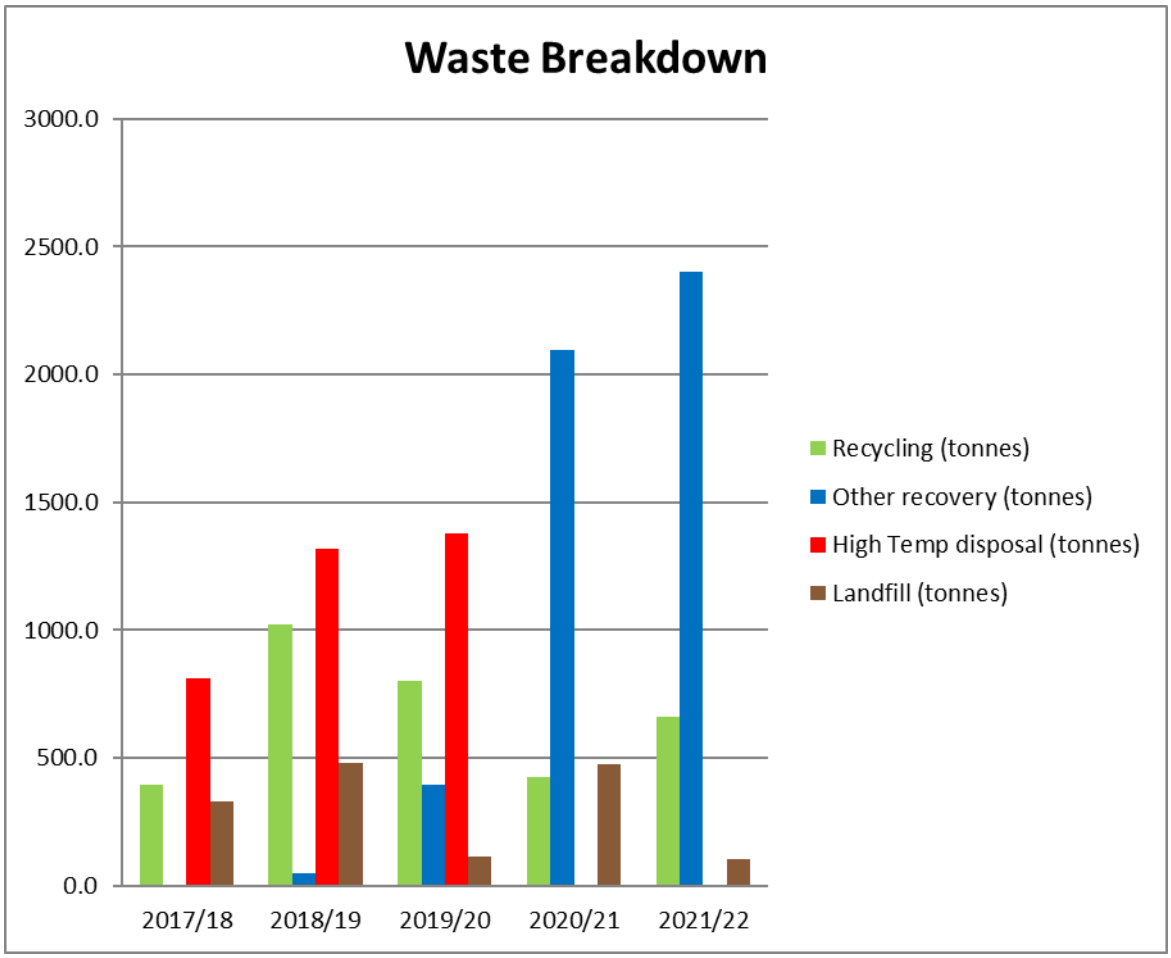
During 2021/22, we installed 48 bike boxes and six cycle shelters, as well as 12 e-bikes to support active travel. We also introduced free bike maintenance sessions at Colchester and Ipswich hospitals and offered our staff the chance to save up to 40% off the cost of a new bike through Cyclescheme.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture of active travel to improve staff wellbeing and reduce sickness as air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors. We have supported ‘Clean Air for Colchester’ and Ipswich Borough Council with air quality monitoring and are working on the introduction of a no idling policy for our sites.

Waste produced

Waste		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Recycling	(tonnes)	586.13	565.65	396.22	396.00	1022.57	799.62	422.46	662.95
	tCO_2e	12.31	11.31	8.32	8.62	22.25	17.08	9.02	14.16
Other recovery	(tonnes)	0.00	0.00	0.00	0.00	49.52	393.08	2094.07	2403.88
	tCO_2e	0.00	0.00	0.00	0.00	1.08	8.55	45.57	52.31
High temp disposal	(tonnes)	608.38	646.45	809.45	809.00	1317.05	1380.19	0.00	0.00
	tCO_2e	133.84	141.57	178.08	177.98	289.75	303.64	0.00	0.00
Landfill	(tonnes)	98.23	130.00	328.90	329.00	479.50	111.63	475.89	101.55
	tCO_2e	24.01	31.77	101.96	113.34	165.18	38.45	163.92	34.98
Total waste (tonnes)		1292.74	1342.10	1534.57	1534.00	2868.64	2684.52	2992.42	3168.38
% Recycled or re-used		45%	42%	26%	26%	37%	44%	84%	97%
Total waste tCO_2e		170.16	184.66	288.36	299.93	478.26	367.72	218.51	101.44

Waste breakdown



Plastic use

The NHS produces many tonnes of plastic waste every year across catering, clinical practice and its supply chain. In recognition of this, we have a plan to reduce our use of single-use plastics and have signed up to the NHS plastics pledge. Colchester and Ipswich hospitals now use reusable sharps bins, reducing the volume of plastic going into the incinerator.

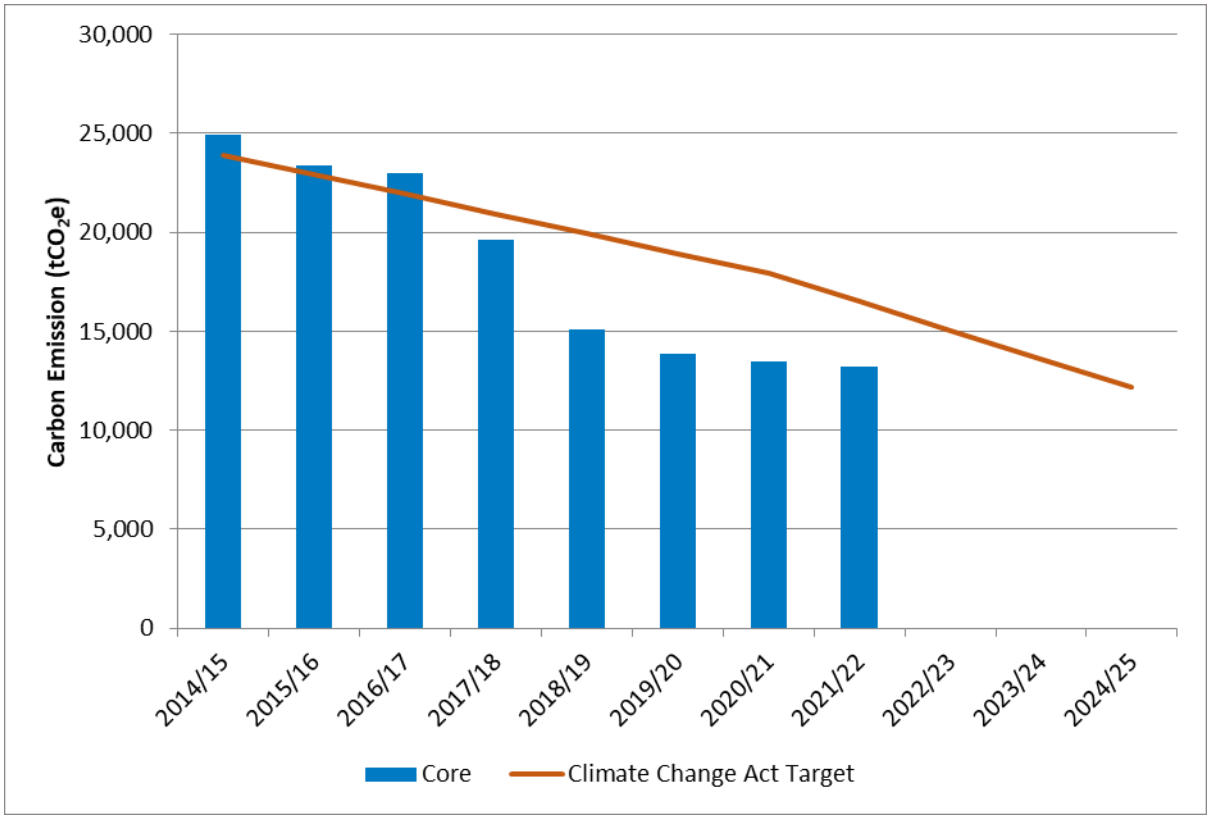
Finite resource use – water

Water consumption has decreased in 2021/22 compared to the previous year, where an increase in demand was assumed to be associated with the pandemic and the increased levels of cleaning and general hygiene.

Water		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Mains	M3	250,807	251,358	270,605	248,286	220,691	275,242	290,916	280,780
Water	tCO2e	228	229	246	226	217	270	285	295

Energy, water and waste carbon emissions progress

Through the various schemes implemented to date, ESNEFT remains ahead of schedule and continues plans for achieving the net zero target.



Source: Systems link as at April 2022

Social value

We recognise the contribution that commissioning, procurement and commercial can have in delivering sustainability and social value, and our duty under the Public Services Value Act.

Adaptation

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of local people during such events, we have developed a number of policies and protocols in partnership with other local agencies

Facilities

Our facilities team deliver support services including cleaning, catering, portering, security, management of car parking, waste and linen and laundry at both Colchester and Ipswich hospitals, as well as Felixstowe, Aldeburgh and Bluebird Lodge community hospitals. They are now also delivering some services at Clacton and the Fryatt community hospitals in Essex.

The department has continued to face challenges during the year as it has supported clinical specialities returning to business as usual following the pandemic. This has included supply issues with specific contractors, with cost pressures to follow into the new financial year as a result of global increases in the prices of some goods.

Another specific impact of the pandemic has been that the Trust, along with others up and down the country, has been unable to undertake the annual patient-led assessment of the care environment (PLACE) review. This will now take place during 2022/23.

Fire safety

The fire safety team is responsible for advising on and assessing fire safety across the Trust.

The fire risk assessment process has recently been streamlined through the use of electronic assessment software. This will help with the timely completion of assessments, as well as the dissemination of information on fire risk.

Our fire safety advisors have been involved in a number of large building projects during the year, including the elective orthopaedic centre, IRCA building and dry riser project in Colchester and pathology building on the Ipswich site. They have also been fully involved as plans for the urgent treatment centre at Ipswich have developed.

The team continues to liaise with both Essex and Suffolk Fire and Rescue Services. All of the Trust's major sites have now been audited by these services and no significant issues have been identified.

During the year, the Trust appointed authorising engineer for fire, who attends quarterly fire safety groups and provides training.

Security

During the year, the security management specialist team has carried out security risk assessments, violence and aggression risk assessments and made recommendations to clinical staff and estates and facilities where changes can be made to the environment, processes and alterations to the premises. All new builds have been reviewed by the team through environmental design system, while recommendations have been made in an attempt to reduce crime.

The team continues to attend multi-disciplinary meetings and advise multiple staff groups on violence and aggression, crime reduction and lone working.

There have been a total of 464 violence and aggression Datix reported incidents for ESNEFT during 2021/22. Of these, there were 187 incidents of clinical assault, (132 in 2020/21), 48 non-clinical assaults (malicious), (eight in 2020/21), 223 incidents of aggressive and threatening behaviour, (189 in 2020/21), four suspected thefts of patients' property (three in 2020/21) and 30 suspected thefts of staff property (four in 20/21).

It can be seen that there has been an increase in all cases. Whilst individual incidents are investigated and we have increased our emphasis on the need to report incidents, the underlying trend increase (which is unfortunately a similar trend across health and social care nationally) is primarily down to

incidents occurring during lockdown. During this period, patients and visitors became very frustrated due to the fact that they could not visit their relatives/ friends and this caused agitation and confrontation.

The security management specialist and staff from the safeguarding team have attended meetings with NHS England and Suffolk and North East Essex Integrated Care System to discuss adopting a violence reduction strategy using the plan, do, check, act (PDCA) approach, an iterative four-step management method to validate, control and achieve continuous improvement of processes. This collaborative working will continue and it is our collective hope that by adopting this system approach across the ICS footprint we will be better able to spot trends and share best practice and data.

During the period we have improved working relationships with Essex and Suffolk Constabularies and have successfully worked with them to mitigate the impact of protests on site whilst avoiding encroaching on the rights to peaceful protest.

Emergency planning

During the past year the emergency planning team have been primarily continuing to support the Trust command and control structure as both strategic and tactical advisors in response to the pandemic and recovery works.

We continue to work with multi agency partners through local resilience forums to ensure incident responses and plans are coordinated to make best use of available resources and expertise to mitigate so far as possible the impacts on local communities. During the past year examples of responses beyond the pandemic that we have been a part of have included extreme weather events, fuel shortages (caused by panic buying and distribution shortages), supply chain challenges, avian influenza and protests. Throughout these incidents (some which remain ongoing) we have maintained close working relationships with partner agencies and ensured our critical functions have remained active.

During the year the Trust undertook a lead role in the provision of North East Essex Community Services, as such we integrated the emergency planning and incident response arrangements for this service into the wider Trust arrangements at operational, tactical and strategic levels.

We saw the return of the annual core standards assessment process with this year's annual deep dive into the provision of oxygen. With the addition of North East Essex Community Services, the Trust undertook and submitted two returns. Both the community services return and the wider ESNEFT return were substantially compliant with the ESNEFT deep dive returning a full compliance for oxygen.

In addition, the Trust has established a new relationship with South Western Ambulance Service to assist with training frontline staff by creating a train the trainer arrangement. We have also updated our tactical incident commander training to improve our resilience in future incident responses.

Both the tactical and strategic EPRR steering groups continue to function covering key incidents, site-specific updates, mass casualty plans, lockdown plans and business continuity plans, as well as tactical and strategic command training lead internally by the EPRR team. The groups have also overseen a series of confirm and challenge workshops assessing and supporting departmental business continuity plans to ensure lessons learnt during the pandemic have been embedded.

Emergency planning and business continuity needs have been integrated into the design of new building and refurbishment works including a substantial input into the resilience of the new emergency department and urgent treatment centre on the Ipswich site and the new orthopaedic elective care centre on the Colchester site.

Social, community and human rights issues

Our place in the community

As an NHS provider and employer, the Trust operates within the requirements of UK and European law, including its responsibilities for equity of access to services, employment and opportunities.

We also operate within the NHS Constitution and have employment and service policies in place which address equality and human rights issues.

Information to, and consultation with, employees

The Trust consults with staff to implement organisational change, including mergers and where services have been redesigned or are being transferred either to or from an external service provider. Where formal consultation is necessary, the Trust is very careful to ensure that communication takes place before the formal consultation period. Once that period is closed, informal communication and consultation continue while any change is introduced.

Throughout any period of consultation and change, staff are given the opportunity for both individual and group communication in a variety of forums with the aim of supporting harmonious change for the staff affected and, ultimately, the service provided to patients. This is supported by our recognised unions.

The intranet, email and Microsoft Teams are also used as rapid methods of communication, while screensavers are also to share simple messages.

There is an established regular briefing by the chief executive and members of the executive team which is cascaded through the organisational management structure. The Board encourages managers to engage with staff members in changing and improving the way in which services are provided.

Equality, diversity and inclusion

In September 2021, ESNEFT submitted a new, clear strategy and action plan to the People and Organisational Development Committee with a series of clear actions and deliverables to ensure that the Trust moved forward with its equality, diversity and inclusion (EDI) agenda. This included:

- funding provision for backfill time for cultural ambassadors
- appointing executive officers of each of the staff networks
- providing administration time to manage the membership database and carry out communication to support the development of staff networks, which have around 1000 members across the Trust
- continuing to focus on zero tolerance of racism
- carrying out a cultural audit to support staff inclusion
- implementing values-based recruitment at application and interview stage
- launching our reverse mentoring programme

We continue to ensure that we meet, and aim to exceed, our legal duties under the Equality Act 2010, Public Sector Equality Duty and national NHS equality requirements to ensure that as an organisation and employer we:

- eliminate unlawful discrimination, harassment and victimisation and any other conduct;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations.

This work is being overseen by the Equality, Diversity and Inclusion Steering Group (EDIG), which is chaired by the director of people and organisational development. The group is responsible for overseeing and providing leadership to the Trust regarding our EDI work. It also provides assurance to the People and Organisational Development Committee and subsequently to the Trust Board that we are complying with the requirements set out in the Equality Act 2010.

We have appointed to a joint post with the integrated care system of strategic lead for equality, diversity and inclusion. The lead will work closely with the associate director of organisational development and culture and the head of patient experience to ensure that self-reported data is available to better understand any key issues relating to our patients and staff. We also have staff networks in place to support colleagues from ethnic minority groups, the LBGTQ+ community and those with a disability while ensuring equity of appointment and opportunity across the Trust.

In September 2021, we developed a new equality, diversity and inclusion strategy which identified three priority areas. They were:

- **Compassionate, inclusive leadership and culture:** Developing a community of leaders who take personal and collective responsibility to inspire and influence inclusive behaviours within the organisation and across our integrated care system. Creating an open and trusting environment that involves and includes everyone at all levels of the organisation to see the importance of EDI for patient care and staff experience.

- **Awareness and education**: To foster a diverse and inclusive workplace we need to create the right levels of EDI awareness and education, focusing on challenging unconscious bias, privilege and micro aggressions and promoting allies. Our staff networks will also play an important role in creating education opportunities for their members and allies. This will be central to engaging the hearts and minds of all of our colleagues while inspiring action and accountability for change.

- **Data**: Monitoring what good looks like to ensure our interventions have an impact and report regularly to the executives and Board. A focused data-driven approach will enable us to dispel any myths regarding our baseline and performance against others while allowing us to track our progress. Our data and reporting will be aligned and benchmarked to monitor of “what good looks like” to ensure our interventions have an impact.

Following the arrival of the Trust’s new director of people and organisational development in January 2021, the strategy has been reframed to ensure its objectives are ambitious and conducive to identifying and addressing intersectionality as well as creating an inclusive workplace where everyone is valued.

Staff diversity networks

The Trust currently has an LGBTQ+ Staff and Friends Network, a BAME Staff Network (EMBRACE) and a Disabled Staff and Carers Staff Network (ESNAble). We have recently increased our staff networks to include support for the armed forces and a women’s network. The networks will continue to be supported by the head of equality, diversity and inclusion and organisational development and will be actively involved and engaged in the decision-making and key activities of the Trust.

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) provides a framework for NHS trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality objectives, and to ensure that employees from black, Asian and minority ethnic (BAME) backgrounds receive fair treatment in the workplace and have equal access to career opportunities. These indicators are a combination of workforce data and results from the NHS Staff Survey.

More information about WRES is available at www.esneft.nhs.uk/about-us/equality-diversity-and-inclusion

The Trust will continue its work to improve race equality, engaging and involving all key stakeholders.

Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for disabled people working for or seeking employment within the NHS. The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

More information about WDES is available at www.esneft.nhs.uk/about-us/equality-diversity-and-inclusion/

The Trust will continue to enhance its policies and practices over the coming year to ensure opportunity and inclusion for all its disabled staff.

Equality of service delivery to different groups

ESNEFT is committed to delivering services which meet the needs of its patients, irrespective of any protected characteristic, and is determined to ensure that no patient suffers harassment, victimisation or a difference in care provision based upon any said characteristic.

During 2021/22, we remained compliant with the accessible information standard by ensuring patients received information in a format that met their needs. Furthermore, the Trust maximised opportunities for patients to access interpreter services where English was not identified as a first language. Hearing loops continue to be available for outpatient clinics across our sites. We consider accessibility challenges and seek positive ways to minimise them through regular internal reviews of the environment.

The Trust's chaplaincy and spiritual care service provides multi-faith support to our patients and families, which has been particularly necessary during the COVID-19 pandemic. In order for our patients to access virtual appointments, both video and audio options have been made available, while we have also maximised opportunities for those who do not have access to electronic options.

Clinical Excellence Awards

The Trust runs an annual process called Clinical Excellence Awards. A three-year interim process which was in place for these awards ended in 2021 while NHS Employers and British Medical Association carried out negotiations around new arrangements.

Although no agreement was reached, new guidance for Clinical Excellence Awards has been published by NHS Employers. For the 2022 round, agreement has been reached with the local negotiating committee and the BMA that the Trust would not have a competitive process and the available funds will be split with eligible consultants.

This will be the last year that this arrangement will be in place as a new Clinical Excellence Awards process which takes into account the new guidance will be operational for the 2023 round.

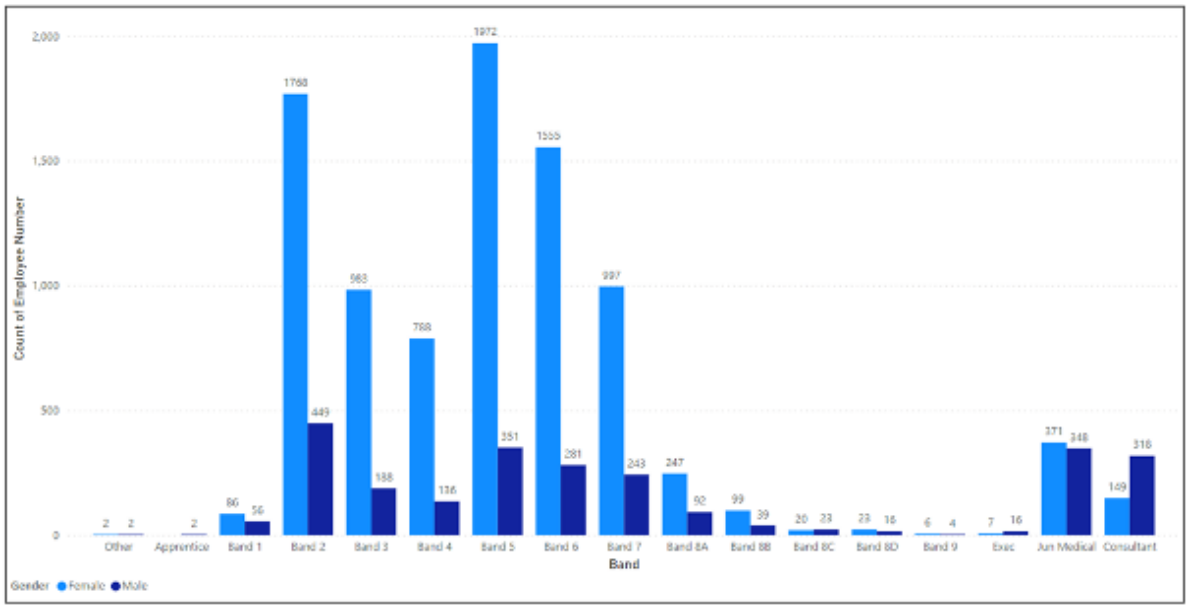
Gender pay gap

The Trust continues to meet its responsibilities under gender pay gap reporting with details from the last report available at: https://gender-pay-gap.service.gov.uk/Employer/RqVQSMNf/2021

Further information on the gender pay gap is available on the ESNEFT website and for national comparison the Cabinet Office website at https://gender-pay-gap.service.gov.uk.

Gender profile

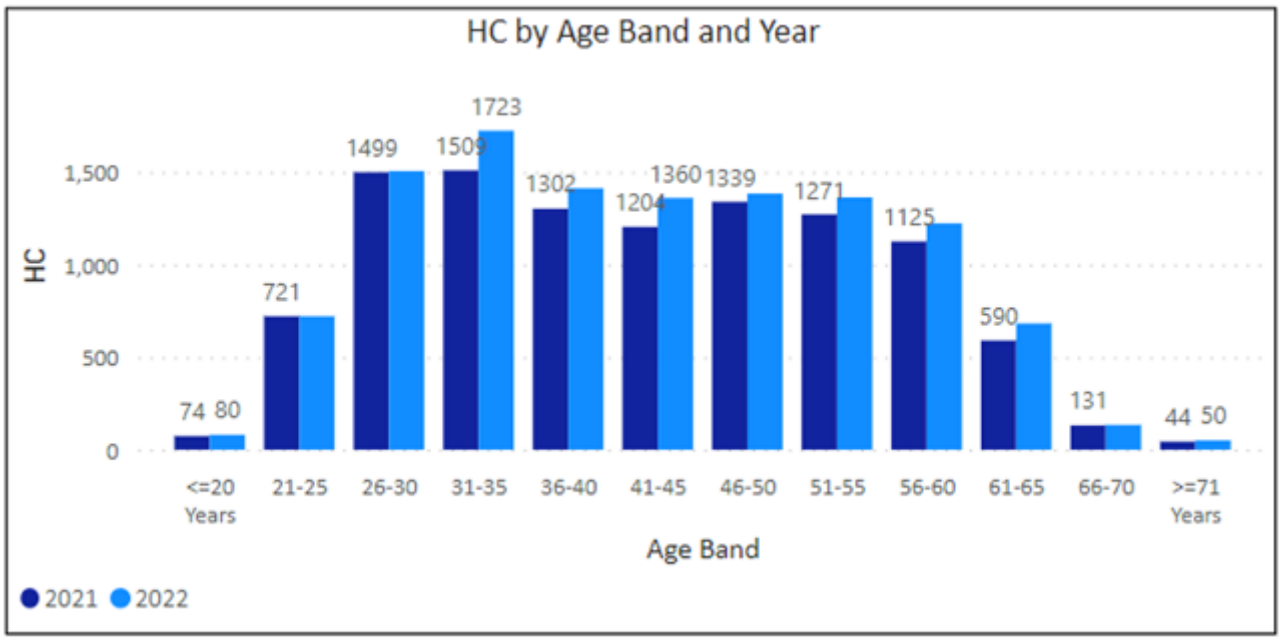
Female staff make up 78% of our workforce while 22% are male, which is consistent with the national gender profile of the NHS. The graph shows the position at March 2022.



Age profile

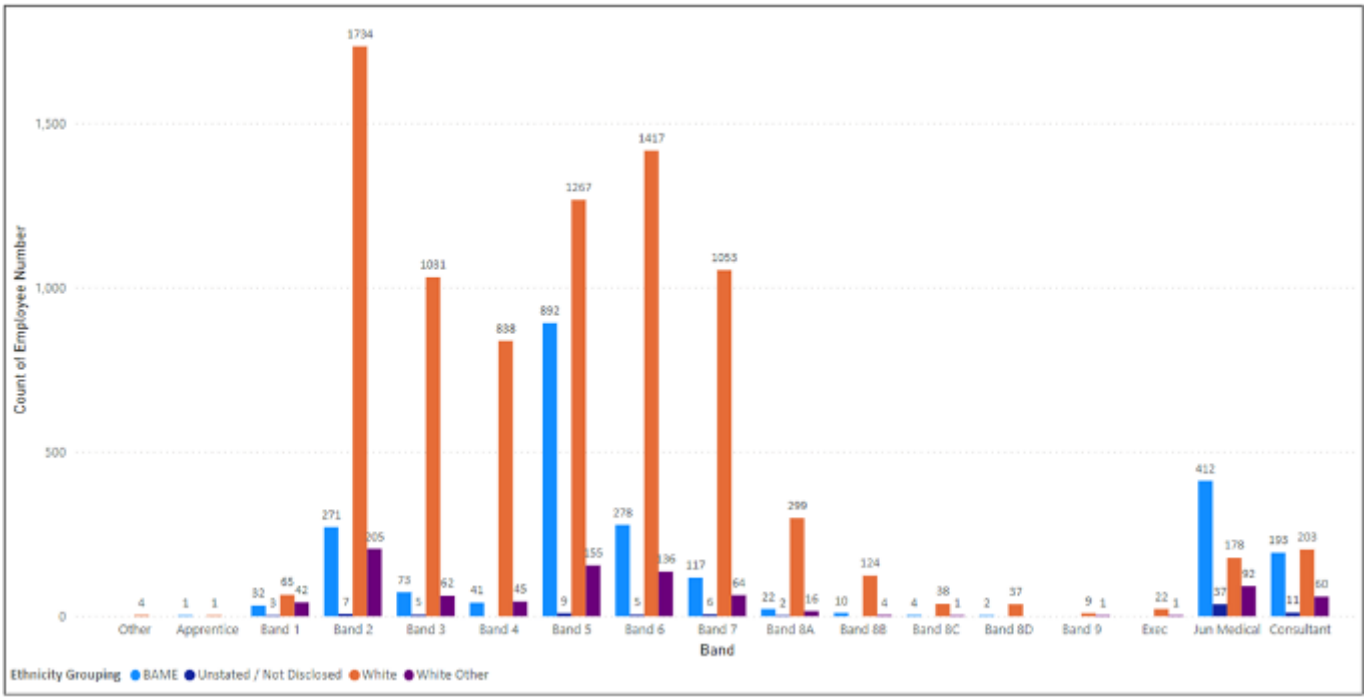
We have 3,165 staff in the age categories 51 to 55 and above. We appreciate that this group will be making plans for their retirement in the near future and have updated our retirement policy to include a variety of options for staff considering retirement and to help retain high quality skills and experience as part of our workforce.

We seek to increase our attractiveness to people of all ages through a variety of measures, including the extensive work experience opportunities and apprenticeships and the promotion of flexible working.



March 2021 and 2022 data

Ethnicity profile



March 2022 data

Health and safety

The estates and facilities team lead Trust-wide health and safety (H&S) governance structures, which allow us to provide a robust and well-developed health and safety management system as part of ESNEFT's risk management strategy. The team continues to promote a positive health and safety culture across ESNEFT by ensuring that it is foremost in the minds of all staff.

Our health and safety policy has been approved by the Board and complies with Section 3 (2) of the Health and Safety at Work Act 1974.

ESNEFT has taken significant steps to ensure we provide an environment which is safe for staff, patients and visitors as a result of the COVID-19 pandemic. This included obtaining individual personal risk assessments for staff and departmental environmental workplace assessments.

All incidents relating to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, have been reported to the Health and Safety Executive (HSE) and investigations have been supported by the corporate health and safety team. The corporate health and safety team have supported investigations where staff or visitors have been injured due to a health and safety concern, which are then uploaded onto our incident reporting and management system.

All departments, including community sites, have been inspected based on the principles of 'plan, do, check, act (PDCA). This is described in detail within the HSE's 'Managing for Health and Safety Guidance (HSG 65). Any safety improvements which were identified were addressed immediately with departments or escalated to line managers. The key components of the PDCA framework that is being applied are summarised as follows:

Plan	determine policy; plan for implantation
Do	profile health and safety risks; organise for health and safety management; implement the plan
Check	measure performance; investigate accidents and incidents
Act	review performance; apply learning

The Trust intranet has a dedicated health and safety page which contains guidance and contact details for the team, including a generic email.

Due to the suspension of Trust-wide mandatory training to refocus on priorities associated with the response to COVID-19, the Trust was unable to meet the health and safety training standard of 95%. There is an agreed plan to meet the standard with mandatory training in 2022/23.

Health and wellbeing

The Trust is committed to providing an effective health and wellbeing service which all staff can access. The service provides rapid access to occupational health, psychological services and our employee assistance programme.

Our newly established wellbeing hub focuses on all aspects of wellbeing. We promote and support physical health, as well as developing links with local services and signposting. Our in-house psychology team provide a range of services including rapid access to individual psychological therapy, team support and brief psychological sessions, as well as webinars and training in strategies to support mental wellbeing and resilience.

Our employee assistance programme continues to provide counselling to staff members and their families, as well as an emotional support helpline and legal and financial support and advice. We also have almost 500 mental health first aiders embedded with teams across the Trust offering support and signposting for staff, linking in with the wellbeing hub resources.

As part of our response to COVID-19, we have worked closely with human resources to ensure that comprehensive emotional, psychological and practical support has been in place for our teams. We also have staff trained in psychological first aid debriefing who support the emotional wellbeing of staff after serious incidents at work, and offer more specialised support through the staff psychology service.

We continue to promote our Schwartz Rounds as another way to promote compassionate care and emotional wellbeing.

Employee assistance

Staff continue to have access to an employee assistance programme for psychological support and a database for non-psychological problems. A helpline is available to support managers with work issues.

Zero tolerance policy against violence and abuse

The Trust will not hesitate to seek the prosecution of anybody who attacks members of staff while at work. The vast majority of assaults are verbal, and on rare occasions staff have been subject to assault which we take very seriously and will involve the police if required.

The safety of our workforce is paramount and a number of procedures are in place to minimise any potential risk to staff. The Trust has an accredited security adviser who runs in-house training courses on how to deal with violent and aggressive situations and how to manage conflict successfully. These courses are mandatory for all frontline staff.

Fraud, bribery and corruption

The Trust supports the continued establishment and maintenance of a strong anti-fraud, bribery and corruption culture among all staff, contractors, the public and patients. Fraud is taken seriously and staff are made aware of how to identify and report fraud correctly.

The Trust endorses the right and duty of individual staff to raise any matters of concern they may have with the delivery of care or services to a patient of the Trust, or about financial malpractice, unlawful conduct, dangers to health and safety or the environment.

We have published an anti-fraud and bribery statement, which supplements our anti-fraud work by setting out our position to all staff, contractors, the public and patients.

We are committed to abiding by the NHS Counter Fraud Authority's counter fraud functional standards and believe that a culture of openness and dialogue is in the best interests of patient care. However, this must be set in the context of our duty of confidentiality to patients and staff. Our Freedom to Speak Up policy sets out the procedures put in place for staff if they wish to raise concerns, and the responsibilities managers at all levels have to ensure these are dealt with thoroughly and fairly.

ESNEFT has recognised the increased risk of fraud with fraudsters nationally exploiting the spread of COVID-19 to facilitate various types of fraud and cyber-crime. Through the work of our local counter fraud specialist we continue to raise awareness of potential fraud and bribery risks.

Overview and scrutiny

Both Essex County Council and Suffolk County Council's health overview and scrutiny committees (HOSCs) considered aspects of the Trust's work and wider system working during the year.

Trust representatives appeared at both committees on specific topics and items of interest, largely with a focus on cancer services, maternity services following the Care Quality Commission's report in spring 2021, and the COVID-19 pandemic and associated recovery.

Public consultations

There were no new public consultations during the period of this annual report.

Other patient and public involvement activities

We continue to work closely with our communities and patient groups. Our patient advocates have met virtually with the head of patient experience and with executive directors during the year. We have also worked in partnership with Healthwatch Essex and Healthwatch Suffolk on specific campaigns such as experience of care during COVID-19.

The generosity of our communities has continued throughout the year with donations to our charity campaigns, including The Blossom Appeal for a new breast care centre and The Children's Appeal for a new paediatric unit at Ipswich Hospital.

Principal risks and uncertainties

The Trust is able to demonstrate compliance with the corporate governance principle that the Board of Directors maintains a sound system of internal control to safeguard public and private investment, ESNEFT assets and service quality. Details of the key risks and uncertainties can be found on page 13 of this report, and within the annual governance statement at page 109.

Effective risk and performance management

The Trust's risk management policy ensures effective governance and compliance with best practice. The Board maintains a framework which ensures timely escalation of risk.

The risk management policy which sets out the principles to ensure performance and quality improvement is connected through a two-way communication between the Board and service delivery areas across ESNEFT, such as wards, clinics and patients' homes. This is underpinned by a clear risk appetite statement, which was approved by the Board of Directors.

A monthly integrated performance report to the Board provides an organisational dashboard which is underpinned and informed by reviews of service level dashboards, with action planning at these levels. Improvement at an operational level is managed through divisional quality and performance meetings and is tested through divisional accountability meetings with executive directors. A programme of patient presentations and patient stories relating to quality priorities and service risks is also delivered to the Board.

In 2021/22 the Board committees provided oversight and routinely received information on all serious incidents and the lessons we have learnt from them.

The Trust has continued to build and strengthen the arrangements for managing incidents. During 2020/21, we continued to report patient safety incidents and investigate to identify system and process failures so that risks could be addressed in a timely manner. ESNEFT is also an early adopter for the patient safety incident response framework (PSIRF), which replaces the requirements to report under the serious incident framework. The PSIRF guides the NHS on how to develop the cultures, systems and behaviours necessary to respond to patient safety incidents in a way that ensures we learn from them and improve.

ESNEFT is a member of NHS Resolution's clinical negligence scheme for trusts.

Effectiveness of systems of internal control

The Board's arrangements for its review and evaluation of the effectiveness of its systems of internal control to manage its principal risks and meet regulatory requirements are also explained in the annual governance statement.

NHS contractual or other arrangements

This section gives information about organisations with whom we had contractual or other arrangements which were essential to the business of the Trust (unless disclosure would, in the opinion of the directors, be seriously prejudicial to that organisation and contrary to public interest):

- NHS North East Essex Clinical Commissioning Group (CCG) and associate commissioners (healthcare commissioning)
- NHS Ipswich and East Suffolk Clinical Commissioning Group and associate commissioners (healthcare commissioning)

- NHS England (specialised, local area and armed forces healthcare commissioning)
- West Suffolk NHS Foundation Trust (clinical services)
- Public Health England (clinical services)
- NHS Blood and Transplant (blood products)
- Essex Partnership University NHS Foundation Trust (mental health services)
- Norfolk and Suffolk NHS Foundation Trust (mental health services)
- Public Health England (microbiology services)
- Allied Health Professionals Community Interest Company (clinical services)

Overview of other material contractual arrangements

The Trust had a number of other procurement arrangements, including:

- Alliance Medical Limited (MRI services)
- Diaverum UK Limited (renal services)
- Steeper Group Ltd (orthotic and prosthetic services)
- GE Capital (equipment leasing)
- Suffolk GP Federation Community Interest Company
- Ramsay Healthcare Ltd (clinical services)

Joint ventures and partnership arrangements

The Trust has always worked in partnership with a number of organisations for the delivery of services. The most significant of these are:

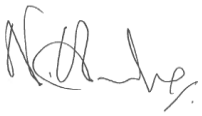
- A section 31 partnership under the Health Act 1999 with Essex County Council, Mid Essex Hospital Services NHS Trust, NHS Mid Essex, NHS North East Essex, NHS South East Essex, NHS South West Essex and Thurrock Council for an integrated community equipment service.
- Partnership arrangements with other NHS trusts, such as Mid Essex Hospital Services NHS Trust and West Suffolk NHS Foundation Trust, for a range of clinical services.

Trust business model

ESNEFT operates a devolved management structure comprising six clinical divisions within three groups and one corporate division. The groups and divisions have delegated authority for governance, performance and expenditure/income and are accountable through the accountability framework to the executive team, led by the chief executive.

Post year-end events

There are no post year-end events requiring to be included within this annual report.



Nick Hulme
Chief Executive
26 September 2022

Accountability report

The accountability report pulls together all of the statutory disclosures relating to NHS foundation trusts and comprises the directors' report, remuneration report, staff report, foundation trust code of governance disclosures, regulatory ratings, statement of accounting officer's responsibilities and the annual governance statement.

Directors' report

The directors' report comprises the details of the individuals undertaking the role of director during 2021/22 and the statutory disclosures required to be part of that report and information relating to quality governance. It is presented in the name of the following directors who occupied Board positions during the year (it also incorporates the operating and financial review):

Name	Title
Helen Taylor	Chair
Eddie Bloomfield	Non-Executive Director
Mike Gogarty	Non-Executive Director
Shane Gordon	Director of Integration Director of Strategy, Research and Innovation
Nick Hulme	Chief Executive
John Humpston	Non-Executive Director
Hussein Khatib	Non-Executive Director
Adrian Marr	Director of Finance
Mike Meers	Director of IM&T
Mark Millar	Non-Executive Director (from 1 January 2021)
Neill Moloney	Managing Director/Deputy Chief Executive
Elaine Noske	Non-Executive Director (from 1 May 2020)
Richard Spencer	Non-Executive Director
Carole Taylor-Brown	Non-Executive Director / Senior Independent Director / Deputy Chair
Giles Thorpe	Chief Nurse
Dr Angela Tillett	Chief Medical Officer
Richard Youngs	Non-Executive Director

Register of interests

All directors are asked to declare any interests on the register of directors' interests at the time of their appointment. This register is reviewed and maintained by the head of corporate governance, and is available for inspection by the public. The register is available for review at each public meeting of the Board of Directors and can be accessed on the Trust website at www.esneft.nhs.uk/about-us/annual-report-and-accounts/esneft-register-of-interests/ or by contacting the Trust's offices at the address on page 5.

None of the executive directors were released by the Trust to serve as non-executive directors elsewhere during the year.

Statement as to disclosure to auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that they ought to have taken as directors in order to be aware of any relevant audit information and to establish that the auditors are aware of that information.

Statutory income disclosures

Non-NHS income

Under the requirements of section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Trust can confirm that income from the provision of goods and services for the purpose of health services in England is greater than the income generated from the provision of goods and services for any other purpose.

Income to the Trust from non-NHS sources has a positive impact on the provision of goods and services for the purposes of the health service, as all income to the Trust is used for the benefits of NHS care.

Other public interest disclosures

Better Payment Practice Code

The Trust is required to pay trade creditors in accordance with the Better Payment Practice Code. This simple code sets out the following obligations of a business to its suppliers:

- bills are paid within 30 days, unless covered by other agreed payment terms
- disputes and complaints are handled by a nominated officer
- payment terms are agreed with all traders before the start of contracts
- payment terms are not varied without prior agreement with traders
- a clear policy exists of paying bills in accordance with contract

We aim to pay at least 95% of our invoices in accordance with these obligations.

	Number	£000
Total non-NHS trade invoices paid in the year	143,655	663,553
Total non-NHS trade invoices paid within target	121,140	585,693
Percentage of non-NHS trade invoices paid within target	84.3%	88.3%
Total NHS trade invoices paid in the year	2,850	81,471
Total NHS trade invoices paid within target	1,805	57,212
Percentage of NHS trade invoices paid within target	63.3%	70.2%

The total potential liability to pay interest on invoices paid after their due date during 2021/22 was £1,082,874, an increase on the amount for 2020/21 (£994,997). There have been minimal claims under this legislation (£0.4k in 2021/22 and £12k in 2020/21), therefore the liability is only included within the accounts when a claim is received.

HM Treasury cost allocation compliance

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Fixed assets

Although there is no predetermined frequency at which property, plant and equipment assets must be revalued, accounting standards require that asset values should be kept up-to-date. Therefore, the frequency of revaluation needs to reflect the volatility of asset values and, in NHS Improvement's view, property assets are likely to require revaluation at least every five years.

A valuation of land and buildings was prepared by the District Valuer Service as at 31 March 2022 based on a desktop update with no site inspections undertaken due to COVID-19. This resulted in a net downward revaluation of buildings by £2.5m. £12.6m of this value was an impairment charged to operating expenses with the other £10.1m being an increase to the revaluation reserve.

The last full valuation of the Trust's land and building assets was carried out at 31 March 2019 by the DVS (the commercial arm of the Valuation Office Agency). Both sites are revalued on the same basis of alternative site with alternative build.

Political or charitable donations

The Trust made no political or charitable donations.

Interest rate or exchange rate risks

The Trust does not have any significant exposure to interest rate or exchange rate risks and therefore does not hold any complicated financial instruments to hedge against such risks. Details of the Trust's financial instruments are shown in the annual accounts.

Accounting policy for pensions and details of senior employees' remuneration

The accounting policy for pensions can be found in the annual accounts, which are in section B of this report. Details of senior employees' remuneration can be found in the remuneration report.

Quality governance

The clinical governance structure supporting the quality agenda is established across ESNEFT. Three executive groups (the Clinical Effectiveness Group, Patient Safety Group and Patient Experience Group) report to the Quality and Patient Safety Committee, an assurance committee of the Board of Directors.

At times of increased operational pressure during COVID-19, reporting was through the Performance Committee.

Well-led framework

We continue to build on our foundations in line with the NHSI/E well-led framework, to continuously develop our governance to underpin the delivery of safe and high quality services and achieve our ambitions for the future.

ESNEFT continues to have in place:

- An established and embedded leadership structure at both Trust Board and divisional level.
- A five year strategy set following extensive internal and external consultation; and a range of enabling strategies to drive the programme (ICT, estates and communication and engagement).
- The ESNEFT values (OAK: optimistic, appreciative and kind) on which we continue to develop the ESNEFT way, alongside our philosophy of ‘time matters’.
- Divisional governance and our accountability framework (aligned to the well-led framework). There is a transparent view of performance throughout the organisation which is reflective of quality, operational performance and financial management.
- A maturing risk management culture.
- Quality improvement faculty supporting continuous improvement and innovation.

We are continuing to mature the risk management culture across ESNEFT services, with positive assurance reviews in 2019/20 and 2020/21.

Our 2020/21 governance and system adaptability was recognised nationally when ESNEFT won a HFMA National Healthcare Finance Award (detailed in our annual report 2020/21). At periods of high operational pressures, the Trust has used these governance arrangements again.

In 2021/22 our Board refocussed our people strategy to support health and wellbeing, new ways of working, innovation and transformation for the benefit of the ESNEFT community.

At our last CQC inspection the CQC has rated well-led as good, noting that:

- Leaders had the skills and abilities to run the Trust and the services. They understood the priorities and issues the Trust and services faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The Trust had a clear vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The Trust philosophy of ‘time matters’ to improve patient experience and achieve strategic objectives was embedded at all levels.

- Staff felt respected and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

- Leaders and staff actively and openly engaged with patients, staff, and equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We continue to hold our teams to account for being well-led through the accountability framework. In 2021/22 we have continued to support our women and children's division to improve its leadership capability and to ensure systems are in place to provide robust assurance against the recommendations of the Ockenden Report and respond to the recommendations from the CQC inspection undertaken in 2021.

We plan to carry out an external evaluation of the Board and governance of the Trust using the well-led framework in quarter four of 2021/22.

Consistency of evaluation

The Trust has reviewed the consistency of its annual governance statement against other disclosure statements made during the year as required by the risk assessment framework, the disclosure statements required as part of this report and the annual plan and against the reports arising from the CQC planned and responsive reviews of the Trust. We have identified no material inconsistencies to report.

Patient safety

Our aim at ESNEFT is to deliver the highest quality healthcare services to every patient, based on national and local best practice and guidance. Each area is responsible for delivering improvement targets which are set annually across ESNEFT. Performance against internal and external quality indicators is monitored by the Patient Safety Group. Assurance for 2021/22 is provided to the Quality and Patient Safety Committee on a monthly basis.

Peer reviews

A peer review is the professional assessment against standards of our healthcare processes and quality of work, with the objective of facilitating improvement. The methodology used during CQC and NHSEI reviews focus on the five key domains of safe, effective, caring, responsive and well-led and has been recognised as best practice. Subsequent peer reviews and 'deep dives' into concerns raised internally and externally continue to be led by the risk and compliance team.

Mortality

The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) give an indication of whether the mortality ratio of an organisation is higher or lower than expected when compared to the national (England) baseline. The HSMR for the 12 months to November 2021 was 108.1, statistically 'higher than expected'. ESNEFT was one of five acute non-specialist trusts of 12 in the east of England with a 'higher than expected' HSMR; five trusts are 'as expected' and two trusts are lower than expected. The SHMI results include deaths within 30 days of discharge. For the 12 months to October 2021, ESNEFT's SHMI was 1.0801, statistically 'as expected'.

It should be noted that both Dr Foster (HSMR provider service) and NHS Digital (SHMI provider service) have excluded patients with a diagnosis of COVID-19 from their mortality ratios as they were not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

Although mortality rates at ESNEFT follow the national seasonal trend for acute trusts, death rates are amplified during the winter due to serving an older/frail population with multiple chronic comorbidities such as heart failure, renal failure, diabetes, dementia and COPD.

Work is ongoing to make sure that patients arriving at emergency departments (EDs) are rapidly assessed and treated according to national protocols and that, following admission, they are closely monitored and escalated. Additional protocols ensure that patients in higher risk categories are reviewed by an ED consultant prior to appropriate discharge.

We are working with community partners to reduce unnecessary admissions for patients in the last months of life by improving symptom control in the community, allowing patients to be treated in their preferred place of care. In addition, more patients are being treated as day cases or outpatients, reducing the prevalence of hospital-acquired functional decline and healthcare-associated infections, thereby speeding recovery. In addition, there are hospital-based teams which facilitate discharge from the ED with community support, reducing the number of avoidable hospital stays.

The Trust follows national guidance, with a robust mortality review process for in-hospital deaths. Cases are identified and reviewed in line with national mandatory requirements for learning from deaths using pre-defined criteria and multiple data sources. In addition, staff review any death where they feel that death was not 'expected' or where there were care concerns. Where learning or issues are recognised these are collated and fed back to the clinical teams, and are also escalated via the Trust's internal governance system.

Medical examiners continue to provide additional scrutiny by assessing the quality of care, both as described in the health record and through discussion with the bereaved. Since inception of the role, the Trust has maintained 100% compliance with the review of all non-coronial deaths. Every family/carer is offered the opportunity to speak with a medical examiner, which gives them an opportunity to ask questions about the care of their loved one, including clinical decisions, treatment and health conditions. Medical examiners have been able to provide an explanation about the effects of a disease or condition and subsequent treatment which can be help with understanding and allaying concerns; this has been particularly evident in the support given to the bereaved where loved ones died from COVID-19.

Falls prevention

There were 2,497 patient falls across all Trust sites in 2021/22, which is an increase on the previous year (2,256). However, the Trust's bed base has increased due to the partnership with Clacton and Harwich community hospitals. Of these falls, 34 resulted in serious harm, which is a reduction on the previous year (47).

ESNEFT has continued its focus on delivering safe care for all patients. Cohort nursing has been effective and continues to be implemented across all hospital sites. Our aim is to maximise patient safety by identifying patients at risk of falls on admission and continually monitoring them until discharge, while placing a focus on rehabilitation and mobilisation in our community hospitals to reduce the risk of deconditioning.

Additional falls assistive technology has been put in place at our inpatient facilities (including the community hospital settings). The assistive technology supports effective clinical risk management by alerting staff to those patient being at risk of falls being up and moving around, enabling appropriate support to be provided to aid safe mobilisation.

Pressure ulcers

Pressure ulcers remain an unwanted complication of care delivery across ESNEFT. Pressure damage is costly in terms of care complications, ongoing treatment plans and the potential for litigation due to pressure damage being viewed as a possible indicator of clinical negligence. Despite many national prevention campaigns in recent years, pressure ulcer incidence rates continue to rise.

Wounds are categorised in accordance with European Pressure Ulcer Advisory Panel guidelines from category one to category four, with category four being the most severe due to the extent of tissue damage that occurs.

For 2021/22 the prevalence of ESNEFT acquired pressure damage categorised between two and four was 467, which is an increase of 17% on 2020/21, when the figure was 398. There were no recorded category four pressure ulcers in ESNEFT's care. This figure includes medical device-related pressure ulcers that have occurred from the use of non-invasive ventilation and the practice of proning to support breathing recovery of patients with COVID-19.

Our Trust continues to promote the use of the ASKIN (assessment, surface, keep moving, incontinence/ moisture, nutrition/ hydration) care bundle as an effective model of pressure ulcer prevention by ensuring staff embed the model principles into their everyday nursing care. Assessment ensures that patients who are at risk of developing pressure ulcer damage are identified early and appropriate care interventions are implemented to prevent pressure ulcers.

Improvements in patient information

Our patient information strategy continued to ensure healthcare professionals were able to deliver accurate, up-to-date, easy-to-understand, informative and timely information to patients. More than 1,000 different leaflets were available, which were compliant with Department of Health guidelines. In response

to COVID-19 leaflets were made available electronically for patients, thereby complying with infection prevention control standards.

Infection control

The rigorous application of infection prevention and control precautions has continued throughout 2021/22. Audits to assess compliance with hand hygiene, PPE usage and standards of cleanliness have taken place, while cases of nosocomial infections have been investigated so that we can focus on learning and improvement. Our infection prevention and control policies have been updated in line with national guidance and disseminated throughout the Trust.

Clostridium difficile

Cases of Clostridium difficile considered to be acquired in hospital (which are known as hospital-onset healthcare-associated, or HOHA) are:

- those where a specimen was taken on the third day of admission onwards (i.e. ≥ day three when day of admission is day one)
- any case not determined to be HOHA but where the patient was discharged from the organisation within 28 days prior to the current specimen date (where date of discharge is day one).

A review panel made up of infection prevention and control staff from the Trust and our commissioners evaluates each hospital-onset healthcare-associated case. Conclusions are determined as one of three outcomes:

- Outcome one – if direct lapses in care or a breach in policy have led to the case of Clostridium difficile.
- Outcome two – if there is a breach in policy leading to a patient safety issue but not Clostridium difficile.
- Outcome three – there were no direct lapses in care or breaches in policy leading to patient safety issue.

Of the 106 cases in total reported across the Trust sites during 2021/22, there were five cases assessed as outcome one and 64 cases assessed as outcome two or three. There are currently 37 cases outwaiting a final decision.

Continuing with a low number of unavoidable cases is testament to the vigilance of clinical teams and their compliance with best practice. However, there remains work to do relating to antimicrobial prescribing and timely isolation.

MRSA bacteraemia

During 2021/22, there were four hospital-onset healthcare-associated (HOHA) cases of MRSA where the specimen was taken on the third day of admission onwards (i.e. ≥ day three when the day of admission is day one).

There were four community-onset healthcare-associated (COHA) cases (i.e. any case not determined to be HOHA but where the patient was discharged within 28 days prior to the current specimen date (where date of discharge is day one).

Root cause analysis was carried out in every case. Areas for learning relate to compliance with the Trust's MRSA screening protocol, care of PICC lines and standards of peripheral vascular access device documentation.

Gram-negative blood stream infections

E.coli bloodstream infections represent 55% of all gram-negative blood stream infections. As approximately 75% of these cases occur before patients are admitted to hospital, the Trust continues to contribute to a system-wide plan to support improvements across the health economy. There were new trajectories for 2021/22 using the same definition for a hospital-attributed case as for other healthcare associated infections.

There have been no local concerns about hospital-associated cases, which are all reviewed and reported as per the national United Kingdom Health and Security Agency (UKHSA) mandatory reporting programme.

Surgical site infection

Orthopaedic surgical site infection data reporting has been mandatory since 2005. The Trust has also participated in non-mandatory reporting, including vascular surgical site infection surveillance. Any deviations from the national benchmark are investigated and reported to the Infection Control Committee.

Hand hygiene monitoring

We monitor compliance with best practice for hand hygiene in all clinical areas every month. Compliance overall remained above 95%.

COVID-19

We have continued to review guidance issued by UKHSA to promote patient and staff safety during the ongoing pandemic. There have been a multitude of outbreaks of COVID-19 during the year which have been managed with support from the clinical commissioning group, UKHSA and NHSE/I. A root cause analysis is completed for all patients who are identified to have COVID-19 on the eighth day of admission onwards (when day of admission is day 0).

All staff have had the opportunity for a risk assessment to ensure their health and safety within the workplace. Staff also have access and training regarding the use of personal protective equipment (PPE).

Improving our patients' experience

Your experience is our responsibility

We remain fully committed to improving patient experience and providing high quality, safe and effective services, while putting patients, relatives and carers at the heart of everything we do.

We continue to welcome complaints as a tool for learning and making improvements. Following the merger, our Patient Advice and Liaison Service (PALS) and the complaints team were aligned to ensure anyone contacting them would receive a consistent and high standard of support, although the teams continue to provide local support to each hospital as enquiries remain site-based.

We are committed to learning from incidents and ensure our teams are aware of all lessons to be learnt for their areas, therefore reducing the risk of serious incidents, never events and serious complaints.

We collect patient feedback from many sources and use this information to inform service development and improvement programmes.

Privacy and dignity

Maintaining patients' privacy and dignity is fundamental to providing a high standard of care. Due to the COVID-19 pandemic, no national inpatient survey was undertaken. Despite this, the Trust continues to focus on treating patients with privacy and dignity, which is included on the extended clinical induction for all members of the multidisciplinary team.

Delivering same sex accommodation

The NHS Constitution confirms a patient's right to dignity and respect. The Trust is committed to treating all patients with privacy and dignity in a safe, clean and comfortable environment.

We are compliant with the government requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will share the room where they sleep with members of the same sex, and that same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will happen only when clinically necessary, for example, where patients need specialist equipment such as in intensive care or the high observations unit.

If our performance falls short of the required standard, this is reported to North East Essex CCG or Ipswich and East Suffolk CCG. We also have an audit mechanism to make sure we do not misclassify any of our reports. We record the results of that audit as part of our patient experience audits.

Patient and public involvement

As an NHS foundation trust, we are committed to the principle of public, patient and staff involvement. Public and staff members have elected governors to represent their views and to work with the Trust to ensure patients' views are taken into consideration at all times.

Due to the COVID-19 pandemic, limited events have taken place during 2021/22.

How the Trust monitors patient experience

We value the feedback we receive from patients about their experiences of receiving care and gather it in several different ways.

The NHS Friends and Family Test (FFT) is well-established across the adult inpatient, maternity and emergency department (A&E) pathways. Responses are largely collected by leaflet, as well as via SMS and the telephone for patients using the ED. FFT reports are sent to the Trust's divisions and wards both weekly and monthly, results are discussed and reviewed at the Patient Experience Group, then reported through to the Quality and Patient Safety Assurance Committee and shared with commissioners. During COVID-19, the national requirement for FFT was suspended; however, local feedback was continued to be sourced so that any key issues in relation to patient experience were highlighted and acted upon.

Compliments and commendations are recorded and reported on a monthly basis. Feedback which is posted on online via forums such as NHS Choices, Care Opinion and Healthwatch is collected and shared via the patient experience team. Complaints and PALS also remain a rich source of feedback for learning and improvement and, where necessary, may also look into issues which have been raised online.

Using online and social media to engage and communicate

The Trust's communications team uses social media, namely Facebook and Twitter, to further engage and communicate with service users.

As of the end of March 2022, our Team ESNEFT Twitter account (@Team_ESNEFT) had 2,945 followers, our ESNEFT Twitter account (@ESNEFT) had 5,982 followers, our Facebook page had 13,992 followers and our Instagram account had 1,421 followers. Facebook encourages people to recommend and review services based on personal experience.

The communications team responds to all appropriate comments, reviews and messages on its social media pages, positive or negative, escalating any issues as appropriate

NHS Choices

The NHS Choices website (www.nhs.uk) allows people to leave compliments or feedback about our hospitals and services. These comments can be seen by anyone who visits the website and helps people to make decisions about where they chose to receive their treatment.

ESNEFT was reviewed 128 times between April 2021 to March 2022. This total included 49 reviews for Ipswich Hospital, 77 reviews for Colchester Hospital and two reviews for ESNEFT.

Our patient experience team responds to the reviews on NHS Choices, signposting patients to relevant services and departments as appropriate, along with escalating any issues as required.

Patient-led Assessments of the Care Environment (PLACE)

Patient-led Assessments of the Care Environment, or PLACE, are an annual review of the various ESNEFT sites is carried out by a group of patient and staff assessors. They consider the patient environment from a non-clinical perspective and examine, in particular, cleanliness, how dementia friendly and accessible the environment is, whether it protects the privacy and dignity of patients and the quality of the food and hydration services.

PLACE assessments were not carried out in 2021/22 due to COVID-19.

Engaging our staff in developing a patient experience approach

We continued to engage staff in developing a personal approach which improves the patient experience. In recruitment, all job descriptions, person specifications, adverts and questions at interview reflected the attitudes, behaviours and standards we expect of employees.

All new staff attended a corporate induction where a half-day was dedicated to patient experience and what all staff must do in terms of behaviours to ensure the Trust is consistently at its best.

Spiritual care and chaplaincy

We have a caring and responsive trust chaplaincy team and approximately 60 chaplaincy multi-faith volunteers, as well as faith/belief visitors whom we are able to call upon to provide appropriate rites and rituals to patients, carers, and staff who request them.

Our Trust chaplains have seen a substantial increase in referrals and contacts from staff, clergy, family members and volunteers. These cover different facets of care from cradle to grave and include spiritual, religious, emotional, and pastoral care, Holy Communion, prayers, naming and blessings, baptisms and

funerals and end of life support. Our team was also privileged to work with patients and their partners to arrange emergency marriages in the past year.

Patient advice and liaison service (PALS)

Our Patient Advice and Liaison Service (PALS) aims to help patients, carers, relatives and families resolve problems as quickly and easily as possible by investigating their concerns or putting them in touch with the appropriate member of staff. The number of PALS contacts from 1 April 2021 to 15 March 2022 was 6734, compared to 4933 in 2020/21. This is an increase of 36.5%. This is reflective of the restrictions on visiting and difficulties in communications with wards and teams.

Compliments

The Trust received 637 compliments in the period 1 April 2021 to 15 March 2022. Compliments were received in several forms, including letters, cards, gifts, emails and through the local press. Where staff are named they are, where possible, informed and this aids morale and improves staff experience.

Our wards also received more than 10,500 gratuities directly, such as chocolates and biscuits, to thank staff for their care.

Complaints

The Trust received 1150 complaints in the period 1 April 2021 to 15 March 2022, compared to 1000 received in 2020/21. This is an increase of 15%.

During the period 1 April 2021 to 15 March 2022, 91% (994) of complaints received were responded to within the 28-working day (or an agreed revised) timeframe, against a Trust target of 100%. This is an increase from 89% 2020/21.

We have worked extremely hard to improve the quality of complaint responses. However, in some cases the complainant has remained dissatisfied, either because not all their concerns were addressed or they challenged some aspects of the response. In such cases the complaint has been re-opened for further investigation. Re-opened complaints are generally resolved with either a face to face meeting or a further letter of response. There were 65 complaints reopened between 1 April 2021 and 15 March 2022, an increase from 44 reopened in 2020/21.

Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

A total of 26 ESNEFT complaints were subjected to independent review by the Parliamentary and Health Service Ombudsman (PHSO) – 18 for Colchester and eight for Ipswich. Of these, 14 remain open and under investigation

Acting to improve our complaints process

Every effort is made to ensure a senior manager calls a complainant within one working day of the complaint being logged to gain clarity on their concerns and offer apologies for the poor experience. A formal acknowledgement letter is also sent within three working days.

During the period from 1 April 2021 to 15 March 2022, the Trust achieved 95% compliance in making courtesy calls within one working day and 99.9% compliance in sending out acknowledgement letters within three working days

Service improvements following complaints

The Trust ensures that complaints are reviewed at divisional clinical governance meetings so that lessons can be learnt and changes made to practice.

During the COVID-19 pandemic, the patient experience team introduced *Letters to Loved Ones* to support communication between patients and their relatives while visiting was suspended. Between 1 April 2021 and 29 February 2022, a total of 1417 letters were received into the Trust – an increase from 1115 received in 2020/21.

The increase in numbers of letters received shows the value of this service for our patients and their families and the services will therefore continue, headed by the patient experience and palliative care teams.

Our Board of Directors

The Board of Directors functions as a corporate decision-making body. The duty of the Board and of each director individually is to ensure the long-term success of the Trust in delivering high quality health care. As a Board, all directors have the same status and as non-executive and executives sitting on a single Board, operate on the principle of a “unitary board”.

All the powers of the Trust shall be exercised by the Board of Directors on behalf of the organisation. The rules and regulations within which the Board is expected to operate are captured in the Trust’s corporate governance documents, which include the organisation’s constitution (which contains the standing orders for the Board of Directors), its schedule of matters reserved for Board decision, standing financial instructions and scheme of delegation. These documents explain the respective roles and responsibilities of the Board of Directors and Council of Governors, the matters which require Board and/or council approval and matters which are delegated to committees or executive management.

Collectively the Board of Directors have responsibility for:

- Providing leadership to the organisation within a framework of prudent and effective controls.
- Supporting an appropriate culture, setting strategic direction, ensuring management capacity and capability and monitoring and managing performance.
- Facilitating the understanding on the part of governors of the role of the Board and the systems supporting its oversight of the organisation.

Disagreements between the Board of Directors and Council of Governors are resolved through a process which aims to achieve informal resolution in the first instance, following which a formal process will be taken which involves a resolution for discussion at a Board meeting.

The Board takes active steps to ensure it interacts appropriately with the Council of Governors. Governors attend regular informal meetings with the Trust chair and are regular observers of the Board assurance committees. Non-executive directors are invited to attend the Council of Governor meetings and governors attend the public Board meetings. The lead governor is invited to attend the Board meeting as an attendee at every meeting.

The limitations set on the delegation to executive management require that any executive action taken in the course of business does not compromise the integrity and reputation of the Trust and takes account of any potential risk, health and safety, patient experience, finance and working with partner organisations.

Appointment and composition of the Board of Directors

The Board of Directors is made up of full-time executive directors and part-time non-executive directors (NEDs), all of whom are appointed because of their experience, business acumen and/or links with the local community. The Trust considers all of its non-executive directors to be independent.

The Board comprises a chair, seven further NED positions and seven voting executive directors. The Council of Governors appointed the chair and other NEDs in accordance with the constitution and in line with paragraphs 19(2) and 19(3) respectively of schedule 7 of the National Health Service Act 2006. The NEDs were appointed by the Council of Governors following national recruitment. In line with the Trust’s constitution, these appointments and reappointments were approved by the Council of Governors.

The Board is content that its balance, completeness and effectiveness meet the requirements of an NHS foundation trust.

Register of interests

All directors are asked to declare any interests on the register of directors' interests at the time of their appointment. This register is reviewed and maintained by the head of corporate governance, and is available for inspection by the public. The register is available for review at each public meeting of the Board of Directors and can be accessed on the Trust website at www.esneft.nhs.uk/about-us/annual-report-and-accounts/esneft-register-of-interests/ or by contacting the Trust's offices at the address on page 5.

None of the executive directors were released by the Trust to serve as non-executive directors elsewhere during the year.

About the non-executive directors

	**Helen Taylor** **Appointed:** 1 January 2020 as substantive Trust Chair **Term of office:** Expires 31 December 2022 Chair of the Board of Directors and the Council of Governors and a member of the Remuneration and Nomination Committee. Helen trained as a nurse and has held a number of senior positions in health and social care, including Director for Integrated Commissioning and Vulnerable People with Essex County Council and interim CEO with Suffolk Age UK. She has also held director-level positions in social care with the London Borough of Tower Hamlets and North Yorkshire County Council, and was previously National Policy Lead for Adult Social Care and Older People with the Audit Commission.
	**Eddie Bloomfield** **Appointed:** 1 November 2018 and appointed to second term of office 1 November 2021. **Term of office:** Expires 31 October 2024 Chair of the Performance Committee and Charitable Funds Committee and a member of the Audit and Risk Committee and Remuneration and Nomination Committee. Eddie has held four chief executive roles at the Ministry of Justice, which included Head of the Court Funds Office and Head of the Office of the Accountant General Public Trustee and as HM Chief Inspector of Court Administration for England and Wales. He is involved with several charities in and around Colchester in trustee and other voluntary positions, and brings extensive experience in political, financial management and change management. He was previously a non-executive director at Colchester PCT.

Hussein Khatib
Appointed: 1 April 2019
Term of office: Expires 31 March 2022

Chair of the Quality and Patient Safety Committee and member of the Performance Committee and Remuneration and Nomination Committee.

Hussein has experience of working in a senior clinical position in the NHS and substantial senior or board-level experience. He has a track record of executive leadership gained in a complex organisation.

Mark Millar
Appointed: 1 January 2021
Term of office: Expires 31 December 2023

Deputy Chair of the Board of Directors, Chair of Audit and Risk Committee and a member of the Performance Committee and Remuneration and Nomination Committee.

Mark has a long and distinguished career in the NHS as a Chief Executive and Director of Resources, having held a number of roles. Mark served as a non-executive director at Royal Papworth NHS Trust for seven years. He is currently the elected President of the Association of Chartered Certified Accountants.

Elaine Noske
Appointed: 20 May 2020
Term of office: Expires 31 April 2023

Chair of the Innovation Committee and a member of the Quality and Patient Safety Committee, Charitable Funds Committee and Remuneration and Nomination Committee.

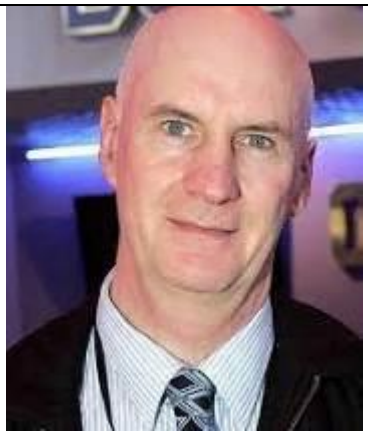
Elaine has held a variety of roles during more than 25 years with BT, and has vast experience of transformation projects, technical product innovation and development. Her current role at BT is focused on cyber security.

Elaine originally served as a non-executive director with ESNEFT from May 2016 to November 2018 and re-joined as an interim NED in May 2020 before becoming substantive in November 2020. She was previously a school governor at Ipswich High School and a mentor with the Prince's Trust.

Richard Spencer
Appointed: 1 November 2018 and appointed to second term of office 1 Novembner 2021.
Term of office: Expires 31 October 2024

Senior Independent Director, Chair of the People and Organisational Development Committee and a member of the Performance Committee and Remuneration and Nomination Committee.

Richard is a former Director of Culture and Policy and Director of Corporate Social Responsibility at BT, and also worked as the company's Head of Strategy and Partnerships. Since taking early

	retirement in 2017, he has been appointed to the Communication Consumer Panel by the Department of Digital, Culture, Media and Sport and continues to act as an executive coach. He is also trustee of a homeless charity based in Colchester.
	**John Humpston** **Appointed:** 1 November 2021 **Term of office:** Expires 31 October 2024 Chair of the Remuneration and Nomination Committee and a member of the People and Organisational Development Committee and Charitable Funds Committee. John began his career in the NHS as a Human Resources Director before going on to work at board-level in four national charities and professional membership organisations – Citizen's Advice, Royal College of Nursing, Crisis and Emmaus. He has held a variety of non-executive board roles in the public, health, community and voluntary sectors. John is currently a non-executive director of Living Sport, Groundwork East and Emmaus Cambridge. He is also the past Regional Director and Chair of East of England Samaritans and continues to work with the Samaritans as a listening volunteer.
	**Mike Gogarty** **Appointed:** 1 November 2021 **Term of office:** Expires 31 October 2024 Member of the Quality and Patient Safety Committee, Innovation Committee, Audit and Risk Committee and Remuneration and Nomination Committee Mike lives in Suffolk and before retirement spent much of his working life in Director of Public Health roles in Essex. He started his career as a GP in Clacton and lived in Tendring for more than thirty years.

Associate non-executive directors

Mark Ridler and Andy Morris are associate non-executive directors with ESNEFT:

- Mark is a member of the Quality and Patient Safety Committee and Innovation Committee.
- Andy is a member of the People and Organisational Development Committee and the Audit and Risk Committee.

About the executive directors

	**Nick Hulme** **Chief Executive** **Appointed:** 17 May 2016 **Term of office:** Permanent **Notice period:** Trust: six months; employee: three months Trust Accounting Officer. Responsible for corporate strategy, external relations, transformation plan, regulation and compliance, leadership. **Twitter:** @Nickhulme61 Nick has worked in the NHS for more than 30 years. He was appointed Chief Executive of Ipswich Hospital in January 2013, and also became Chief Executive of Colchester in May 2016.
	**Shane Gordon** **Director of Strategy, Research and Innovation** **Appointed:** 2 March 2015 **Term of office:** Permanent **Notice period:** Trust: six months; employee: three months **Twitter:** @DrShaneGordon Shane was previously Clinical Chief Officer of North East Essex Clinical Commissioning Group. He was Associate Medical Director of the East of England Strategic Health Authority and is a member of the Royal College of General Practitioners and the Royal College of Surgeons.
	**Mike Meers** **Director of Digital and Logistics** **Appointed:** 1 January 2018 **Term of office:** Permanent **Notice period:** Trust: six months; employee: three months Mike has worked within local NHS services for more than 27 years managing information technology services and their transformation.

Neill Moloney
Managing Director/Deputy CEO
Appointed: 1 January 2018
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @NeillMoloney

Neill acted up a Chief Executive from 11 October 2021 to 21 January 2022, as Nick Hulme was seconded to work with the national vaccination team.

Neill has worked in the NHS for more than 26 years, 11 of which have been as an Executive Director. He has extensive experience and expertise in operational management, planning and performance, as well as leadership in commissioning and information.

Adrian Marr
Director of Finance
Appointed: 7 October 2019
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Adrian has worked in the NHS for over 30 years. He has undertaken Finance Director roles in provider and commissioning organisations, and was previously director of finance for NHS England in the east of England.

Giles Thorpe
Chief Nurse
Appointed: 23 November 2020
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Giles has previously held roles as Director of Clinical Quality and Deputy Chief Nurse at Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's). He was previously Deputy Director of Nursing at Colchester Hospital and before that Deputy Director of Clinical Governance at Basildon and Thurrock University Hospitals.

Giles has also held national roles at NHS Blood and Transplant and is a graduate of the Nye Bevan programme run by the NHS Leadership Academy.

Dr Angela Tillett
Chief Medical Officer
Appointed: 9 March 2015
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @angela_tillett

Angela trained at University College London and started as a Paediatric Consultant in Colchester in 2001. Her roles included Lead Clinician for Paediatric Services, Divisional Director for Women's and Children's Services and subsequently Divisional Director for Surgery before she was appointed to the Chief Medical Officer role.

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests. They are asked to register any changes to their declarations and to confirm, in writing, on an annual basis that the declarations made are accurate. The register is maintained by the Trust's director of governance.

Former executive and non-executive directors (NEDs)

Carole Taylor-Brown, NED, was appointed on 1 November 2018 and left the on Trust 31 October 2021.

Richard Youngs, NED, was appointed on 1 November 2018 and left the on Trust 31 October 2021.

Evaluation of the Board of Directors' performance

The Board of Directors met monthly. There were 12 meetings of the Board, five of which were held in public.

They took place on 8 April 2021, 6 May 2021 (public), 3 June 2021 (seminar only), 14 June 2021, 8 July 2021 (public), the August meeting was cancelled, 9 September 2021 (public), 7 October 2021, 4 November 2021, (public), 2 December 2021, 6 January 2022, 3 February 2022 and 3 March 2022 (public).

All meetings were held via Microsoft Teams (video conferencing).

Name	Title	Number attended
Eddie Bloomfield	Non-Executive Director	12/12
Shane Gordon	Director of Strategy, Research and Innovation	11/12
Nick Hulme	Chief Executive	7/12
Hussein Khatib	Non-Executive Director	12/12
Adrian Marr	Director of Finance	12/12
Mike Meers	Director of Digital and Logistics	9/12
Mark Millar	Non-Executive Director	11/12
Neill Moloney	Managing Director	11/12
Elaine Noske	Non-Executive Director	11/12
Richard Spencer	Non-Executive Director	8/12
Carole Taylor-Brown	Non-Executive Director	6/12
Helen Taylor	Chair	12/12
Giles Thorpe	Chief Nurse	12/12
Angela Tillett	Chief Medical Officer	12/12
Richard Youngs	Non-Executive Director	6/12

Board development

Board development takes place in workshops and seminars on the days when the Board meets. During the year, the Board had sessions on the Board Assurance Framework, recovery and reform, community services, strategy review, objective deep dive (lead on integration of care) and the role of the Board as corporate trustee.

Ongoing development

The chair holds team and one-to-one meetings with the chief executive and non-executive directors as required.

Appraisal process for the chair and non-executive directors

The chair and head of corporate governance work with the Council of Governors to maintain the appraisal process for the chair and non-executive directors.

The chair is formally appraised by the senior independent director and lead governor in conjunction with the Council of Governors via its Appointments and Performance Committee. Appraisal of non-executive directors is carried out by the chair, advised by the lead governor, and reported in the Council of Governors via the Appointments and Performance Committee.

The chair's appraisal was shared with the Council of Governors on 9 June 2022 and has been submitted to NHS England/ Improvement.

The chair carried out the non-executive director appraisal process in April 2021. During 2022, appraisal meetings will take place in May. Executives, NEDs and governors have also been taking part in the 360 degree feedback process.

Appraisal process for executive directors

An appraisal process is in place for the chief executive and other executive directors. The chair appraises the chief executive and the chief executive appraises the executive directors, reporting to the Remuneration and Nomination Committee on the process and outcome of the appraisals.

Governance arrangements

As a consequence of COVID-19, the Board streamlined the governance structure for 2021/22 whilst ensuring regular oversight of business. The committees were all chaired by a non-executive director, met regularly based on an agreed business cycle, and reported to the Board of Directors. The lead governor observed and provided feedback to the Council of Governors on their effectiveness.

The committees of the Trust Board for 2021/22 were:

- Audit and Risk Assurance Committee
- Charitable Funds Committee
- Remuneration and Nomination Committee
- Performance Assurance Committee (sat twice as Integrated Assurance)
- Quality and Patient Safety Committee
- People and Organisational Development Committee
- Innovation Committee

Attendance at committee meetings 2021/22

	Audit and Risk	Innovation	P&OD *	Performance	Q&PS +	Remuneration
Eddie Bloomfield	6 (7)	2 (3)		11 (12)		3 (3)
Mike Gogarty	1 (2)	1 (3)				2 (2)
Shane Gordon		3 (3)	4 (5)			
Nick Hulme		1 (3)	2 (3)			1 (3)
John Humpston		0 (3)	1 (1)			2 (2)
Hussain Khatib		0 (3)		10 (12)	3 (3)	1 (3)
Neill Maloney		2 (3)		8 (12)	1 (3)	
Adrian Marr		1 (3)	4 (5)	10 (12)		
Mark Meers		3 (3)				
Mark Millar	7 (7)	3 (3)		5 (6)	3 (3)	2 (3)
Elaine Noske		3 (3)				
Richard Spencer		1 (3)	5 (5)	12 (12)		1 (3)
Helen Taylor		1 (3)				1 (3)
Carole Taylor-Brown		0 (2)	2 (3)	6 (7)		1 (1)
Giles Thorpe		1 (3)	5 (5)	11 (12)	3 (3)	
Angela Tillett		2 (3)	5 (5)	10 (12)	2 (3)	
Richard Youngs	5 (5)	1 (2)				
Andy Morris	6 (7)	2 (3)			3 (3)	1 (3)
Mark Ridler		3 (3)	5 (5)	2 (4)		2 (3)

*Performance and Organisational Development Committee
+Quality and Patient Safety Committee

Audit and Risk Assurance Committee

This committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) which support the achievement of the organisation's objectives.

It also ensures there is an effective internal audit function, established by management, which meets mandatory NHS internal audit standards and provides independent assurance to the Audit and Risk Assurance Committee, chief executive and Board of Directors.

The committee also reviews the work and findings of the external auditors appointed by the Council of Governors and considers the implications of their findings and recommendations and related management responses.

The Audit and Risk Assurance Committee held six meetings: 26 May 2021, 10 June 2021, 19 July 2021, 22 September 2021, 15 December 2021 and 16 March 2022

Internal auditors

Internal audit was provided by RSM. Their role is to provide independent assurance that our risk management, governance and internal control processes are operating effectively.

External auditors

The Council of Governors appointed BDO UK LLP as the Trust's external auditors.

The responsibility of the Trust's external auditors is to independently audit the financial statements and part of the remuneration report in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

The Trust ensures that the external auditors' independence is not compromised by work outside the Audit Code by having an agreed protocol for non-audit work. Non-audit work may be performed by the Trust's external auditors where the Audit and Risk Assurance Committee's approved procedure is followed, which ensures all such work is properly considered and the auditors' objectivity and independence are safeguarded.

Performance Assurance Committee (sat twice as Integrated Assurance)

Taking the learning from the arrangements put in place during the COVID-19 pandemic, and the related EPRR level four arrangements that were put in place nationally, the Board has determined that a single Performance Assurance Committee should be established to provide oversight and assurance related to all performance matters. It is in place to provide assurance to the Board that the financial and operational performance of the Trust is in accordance with the strategies, plans and trajectories approved by the Board.

This committee's main duties are to:

- Oversee and provide assurance to the Board regarding operational performance and the delivery of the agreed service objectives.
- Monitor and provide assurance to the Board on financial performance and compliance with the agreed financial plans for the period, including meeting the agreed cost improvement plans.
- Monitor and provide assurance to the Board on the quality of service and care being provided to patients through the Trust's services.
- Oversee the arrangements under which the Trust is commissioned to provide services.
- Monitor the related strategic risks and the management and mitigations in place relating to them.

The Performance Assurance Committee held 12 meetings: 27 April 2021, 25 May 2021, 22 June 2021, 27 July 2021, 24 August 2021, 28 September 2021, 26 October 2021, 25 November 2021, 21 December 2021, 26 January 2022 (sitting as Integrated Assurance), 23 February 2022 (sitting as Integrated Assurance) and 30 March 2022.

Charitable Funds Committee

The Charitable Funds Committee has responsibility to adhere to the principles and responsibilities of trusteeship as defined by the Charity Commission and the Trustee Act 2000, section 11. In the main, the committee reviews the policies and procedures for fundraising, acceptance and expenditure, including the internal control arrangements operating within the Trust for charitable funds.

The committee includes representation from operational senior managers from across the Trust.

The committee held nine meetings: 27 April 2021, 25 May 2021, 22 June 2021, 27 July 2021, 28 September 2021, 26 October 2021, 30 November 2021, 25 January 2022 and 29 March 2022.

Remuneration and Nomination Committee

The Remuneration and Nomination Committee also fulfils the role of a nomination committee and reviews the structure, size and composition of the Board of Directors and makes recommendations for changes where and when appropriate. It also considers succession planning arrangements, taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board of Directors. This committee is responsible for advising on the appointment and/or dismissal of executive directors. Board appointments are made through a competitive process following Trust recruitment policies with remuneration agreed using national benchmarks. It is also responsible for the approval of their remuneration and terms of service and the monitoring of their performance against delivery of organisational objectives.

The committee is chaired by John Humpston, Non-Executive Director, and the membership comprises all the non-executive directors. The chief executive, director of human resources and organisational development and the company secretary are routinely invited to attend these meetings except when their own terms and conditions are under discussion. An appointments panel of the Remuneration and Nomination Committee is convened when permanent executive appointments are to be made. All appointments are by public advertisement. External assessors are part of the recruitment process.

The Remuneration and Nomination Committee held four meetings: 2 September 2021, 22 October 2021, 12 January 2022 and 1 March 2022.

Quality and Patient Safety Committee

The committee held four meetings: 29 April 2021, 24 June 2021, 26 August 2021 and 28 October 2021.

People and Organisational Development Committee

The committee held five meetings: 27 May 2021, 29 July 2021, 30 September 2021, 25 November 2021 and 31 March 2022.

Innovation Committee

The committee held three meetings: 29 July 2021, 29 September 2021 and 30 March 2022.

Remuneration report (unaudited)

The purpose of the remuneration report is to provide a statement to stakeholders on the decisions of the Remuneration and Nomination Committee relating to the executive directors of the Board of Directors. In preparing this report, the Trust has ensured it complies with the relevant sections of the Companies Act 2006 and related regulations and elements of the NHS Foundation Trust Code of Governance.

Annual statement on remuneration

Statement from the chair of the Remuneration and Nomination Committee

Decisions on executive remuneration were based on available benchmarking information from NHS England and NHS Improvement, the advice of the executive search firm supporting the appointments and other market intelligence. Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust.

Following publication of NHS Improvement's Guidance on Pay for Very Senior Managers, all new appointments to the Trust where the salary is over £150,000 are subject to an element of earn-back pay. This means that a percentage of base pay (normally at least 10%) is placed at risk, subject to the individual meeting agreed performance objectives.

Remuneration and performance conditions

The remuneration of the directors and non-executive directors does not include any individual performance-related component. Their remuneration follows NHS Improvement's Guidance on Pay for Very Senior Managers in Trusts and Foundation Trusts published in September 2021, is subject to an annual review which takes into account a benchmarking comparison with other similar organisations, general labour market conditions and the Board's collective achievement of organisational objectives.

During the year, the Remuneration and Nomination Committee reviewed benchmarked data to confirm its approach to executive pay and remuneration.

The remuneration of the chair and non-executive directors is decided by the Council of Governors following advice from the Appointments and Performance Committee. To determine the remuneration, the committee uses the data from an annual survey undertaken by NHS Providers. The level of remuneration for non-executive directors is based on an average expected workload of a minimum of four days a month and a minimum of three days a week for the chair.

To determine executive directors' salary levels, the Remuneration and Nomination Committee uses mainly the data from the annual NHS Providers survey, NHSI guidance and along with the benchmarking information provided by external search organisations supporting executive director recruitment.

Decisions relating to salary levels in the rest of the organisation are factored into the Remuneration and Nomination Committee's discussion of executive director salaries and the Appointments and Performance Committee's discussion of non-executive director salaries. The committee does not consult with employees when considering its policy on senior managers' remuneration.

Other than the Trust's chief medical officer, amendments to annual salary are decided by the Remuneration and Nomination Committee. The annual salary of the executive directors is inclusive of all cash benefits other than business mileage. The chief medical officer's salary is in accordance with the medical and dental consultants' terms and conditions of service. The special allowance for undertaking the role of chief medical officer is approved by the Remuneration and Nomination Committee.

There were no new applications to the Treasury during 2021/22 following the benchmarked review of remuneration for the appointments to the Board. The exception to this was a request to approve remuneration of the acting chief executive for four months which was acknowledged

Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.

When determining salary levels, an individual's role, experience and performance, along with independently sourced data for relevant comparator groups are considered. Salary increases typically take effect from 1 April each year.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

In line with our Equality, Diversity and Inclusion Strategy (2020-24) we aim to have visible diversity of our senior team and that they demonstrate inclusive behaviours and a compassionate culture. We actively seek to achieve a year-on-year reduction in gender pay gap and increase the proportion of BAME staff represented at senior levels. All our senior appointments are sourced using dedicated recruitment consultants to gain a diverse candidate pool and maximise the potential to deliver our ambition.

Senior managers' remuneration policy

Contractual compensation provisions for early termination of executive directors' contracts

There are no special contractual compensation provisions for early termination of executive directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the Agenda for Change: NHS Terms and Conditions of Service Handbook (Section 16); or, for those above the minimum retirement age, early termination by reason of redundancy is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Principles on which the determination of payments for loss of office, an indication of how each component will be calculated and whether, and if so how, the circumstances of the loss of office and the senior manager's performance are relevant to any exercise of discretion are considered on a case by case basis by the Remuneration and Nomination Committee.

Annual report on remuneration

Duration of contracts, notice periods and termination payments

Details of contracts and notice periods are summarised in the Board of Directors' profiles section.

Remuneration and Nomination Committee

Details on the meetings of the Remuneration and Nomination Committee are provided on page 70. The committee has a clear policy on the remuneration ranges for every executive director position. Any decisions that fall outside the parameters of the policy, which are due to exceptional circumstances for example, are subject to further discussion and approval by the committee.

Fair pay multiple (subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021/22 was £215,000-£220,000 (2020/21, £250,000-£255,000). This is a change between years of -13.9%. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £125 to £384,187 (2020/21 £135 to £388,028). The lowest is based on zero hours contracts; if we exclude zero hours the lowest annualised salary for 2021/22 is £16,347 (2020/21 is £8,213).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5.3%. A total of 11 employees received remuneration in excess of the highest-paid director in 2021/22.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest-paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2021/22	25th percentile	Median	75th percentile
Salary component of pay	£24,438	£33,752	£46,316
Total pay and benefits excluding pension benefits	£24,438	£33,752	£46,316
Pay and benefits excluding pension: pay ratio for highest paid director	8.90	6.44	4.70

2020/21	25th percentile	Median	75th percentile
Salary component of pay	£23,163	£32,040	£44,503
Total pay and benefits excluding pension benefits	£23,163	£32,040	£44,503
Pay and benefits excluding pension: pay ratio for highest paid director	10.90	7.88	5.67

In the year, the identity of the highest-paid director changed, which has impacted the ratios as the new highest paid director earns 13.9% less. The percentage change in performance pay is detailed below.

Performance pay movement	Change
Change in performance pay and bonuses from the previous year in respect of the highest-paid director	-100%
Average change in performance pay and bonuses from the previous year in respect of all employees (excluding highest-paid director)	-39.0%

The identity of the highest-paid director changed because part of the chief executive's remuneration was paid directly by HM Government for the period he was assisting in the national vaccination programme. The highest-paid director's remuneration was impacted by the award of an inflationary increase in remuneration, in line with the increases awarded to staff more generally. The organisation also had a significant number of successful recruitment campaigns for newly qualified nurses, healthcare assistants and facilities staff, the latter to comply with NHSI/E new agency rules. This has resulted in an increase in the number of staff in the lower paid bands and ultimately impacted on the median pay threshold.

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

Salaries for senior managers are established and maintained taking the following elements into consideration: the individual's role, experience and performance and independently sourced data for relevant comparable organisations. This includes consideration of salary levels at other members of ESNEFT. Salaries for senior managers are formally reviewed every three years with annual interim reviews.

When setting remuneration levels for the executive directors, the Remuneration Committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other leading NHS healthcare organisations of similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader Trust workforce. In assuring itself that the remuneration provided is reasonable, the Committee has considered benchmarking information on Board-level salaries within the NHS, both generally and by reference to provider organisations of similar size and complexity to the Trust.

The Remuneration Committee has responsibility for authorising the engagement of any staff member on a non-agenda for change contract or salary.

Salary and pension entitlement of the Board of Directors

The chief executive has determined that 'senior managers', being those staff in senior positions who have authority or responsibility for directing or controlling the major activities of the Trust, are the executive and non-executive directors. The remuneration, salary and pension entitlements of the Board of Directors are detailed from page 77 onwards. These disclosures have been audited.

The table on page 75 sets out the forward policy of the Remuneration Committee regarding executive remuneration and related benefits.

Forward remuneration policy

	How this component supports short and long term objectives	How this component operates	Maximum payable	Recovery or withholding provisions
Salary	Appropriate salary enables the recruitment and retention of executive directors with the required skills, experience and talent.	Salary is paid pro-rata on a monthly basis, net of tax deductions, in accordance with the employment contract.	As per individual's contracts	There are no recovery or withholding provisions in respect of basic salary.
Bonus	The committee considers that paying bonuses would not support the Trust's objectives.	N/A	N/A	N/A
Incentive schemes	The committee considers that operating an incentives scheme would not support the Trust's objectives.	N/A	N/A	N/A
Notice periods	Having appropriate periods of notice enables the Trust to ensure smooth services during personnel changes.	Each contract makes provision for the notice period to be served by the individual. The committee's policy is that the notice period should usually be six months.	N/A	The period of notice may only be shortened if the committee is satisfied that there are appropriate alternative arrangements in place.
Benefits in kind	No benefits in kind are offered, as the Trust considers them not to be necessary to support objectives.	N/A Some directors show taxable benefits in the table, owing to the operation of Inland Revenue rules. These are not benefits in kind but reflect expenses incurred.	N/A	Any improperly claimed benefits can be reclaimed (or their value) through contractual mechanisms.
Pension benefits	Provision of pension benefits encourages leaders to commit to the organisation. There is a national defined-benefit scheme that salaried leaders automatically enter.	Each executive director participates in the NHS Pension Scheme arrangements, under the relevant statutory regulations.	Trust contribution of 14.3% of salary	There are no withholding provisions for the Trust. Recovery, or withholding of pension payments, is a matter for NHS Business Services and governed by the relevant statutory regulations.
	Some senior staff, including senior leaders, may suffer adverse tax consequences if their lifetime pensions savings exceed a statutory limit.	All staff are offered the opportunity to leave the NHS Pension Scheme and receive additional 16.5% payment.	16.5% of salary	There are no withholding provisions for the Trust.

The policy statements above represent the current view of the committee. The committee is aware that the Department of Health and Social Care is considering issuing updated guidance to the NHS regarding the contractual arrangements for executive directors. Dependent on the contents of that guidance, which may be issued in a way to be compulsory on the Trust, the policy statements above may need to be updated.

The key points in the future remuneration policy in respect of non-executive directors are:

- **Fees:** each non-executive director receives fees for service (not a salary for employment). A single fee is in place for all non-executive directors except the chair, for whom a different fee arrangement has been approved. Additional fees are payable for designated positions, namely the deputy chair, senior independent director and the chair of the Audit Committee.
- **Pensions**: non-executive director positions are not pensionable, and do not participate in the NHS Pension Scheme arrangements.
- **Benefits in kind**: non-executive directors are not eligible for benefits in kind. They are eligible to have expenses properly incurred refunded by the Trust.

Service contract obligations

Obligations contained in the service contracts of directors which could give rise to or impact on remuneration payments are:

- **Notice:** each contract contains provisions related to the giving of notice for the termination of the contract. In the event that the Trust wished to end the contract without the individual working through the period of notice, it would be likely to have to pay remuneration for that period of notice.
- **Redundancy**: in the event of a director becoming redundant, they have contractual rights to redundancy payments. These rights are reflective of those applicable to NHS staff under the Agenda for Change national arrangements, and are limited to one month's payment for each year of relevant NHS service calculated on a maximum annual salary of £80,000. In accordance with national arrangements, any director who leaves with a redundancy payment will be subject to a claw-back arrangement if they return to an NHS position within 12 months of their redundancy.

Directors' and governors' expenses

Information on the expenses of directors and governors is required by the Health and Social Care Act 2012. There were 28 directors eligible to claim expenses during 2021/22. Of these, 11 made claims totalling £7,678.33. This compared with 30 directors eligible to claim expenses during 2020/21, of which 16 made claims totalling £8,589.23. No governors claimed expenses between April 2021 and March 2022.

Nick Hulme
Chief Executive
26 September 2022

Salary and allowances of senior managers (subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Nick Hulme	Chief Executive (1 April to 10 Oct 2021 and 21 Jan to 31 March 2022)	195-200	300	-	-	-	195-200
Neill Moloney	Managing Director / Chief Executive (11 Oct to 21 Jan)	180-185	-	-	-	70-72.5	250-255
Michael Meers	Director of Digital and Logistics	145-150	-	-	-	157.5-160	300-305
Giles Thorpe	Chief Nurse and Director of Infection, Prevention and Control	125-130	300	-	-	40-42.5	170-175
Angela Tillett	Chief Medical Officer	160-165	-	-	10-15	57.5-60	230-235
Shane Gordon	Director of Strategy, Research and Innovation	215-220	300	-	-	-	215-220
Adrian Marr	Director of Finance	175-180	-	-	-	-	175-180
Helen Taylor	Chair	60-65	100	-	-	-	60-65
Edward Bloomfield	Non-Executive Director	10-15	-	-	-	-	10-15
Hussein Khatib	Non-Executive Director	10-15	-	-	-	-	10-15
Richard Spencer	Non-Executive Director	10-15	-	-	-	-	10-15
Carole Taylor-Brown (left 31/10/2021)	Non-Executive Director	5-10	-	-	-	-	5-10
Richard Youngs (left 31/10/2021)	Non-Executive Director	5-10	-	-	-	-	5-10
Mark Millar	Non-Executive Director	10-15	-	-	-	-	10-15
Andrew Morris	Associate Non-Executive Director	5-10	-	-	-	-	5-10

Elaine Noske	Non-Executive Director	10-15	-	-	-	-	10-15
Mark Ridler	Associate Non-Executive Director	5-10	-	-	-	-	5-10
Michael Gogarty (from 01/11/2021)	Non-Executive Director	5-10	-	-	-	-	5-10
John Humpston (from 01/11/2021)	Non-Executive Director	5-10	-	-	-	-	5-10

Please note:

- Salaries for Giles Thorpe and Adrian Marr include payment for untaken annual leave.
- Salaries for Nick Hulme, Shane Gordon and Adrian Marr include pension earn back as a consequence of opting out of the NHS Pension Scheme.
- Salary for Angela Tillett (Chief Medical Officer) includes a long term Clinical Excellence Award (CEA) under long term performance pay in relation to her clinical work.
- Salary for Angela Tillet (Chief Medical Officer) includes her salary for her clinical role, the range of this is £45,000-£50,000 (bands of £5,000).

Comparative table showing salary and allowances of senior managers in 2020/21

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Nick Hulme	Chief Executive	245-250	200	0-5	n/a	0-2.5	250-255
Neill Moloney	Managing Director	170-175	0	0-5	n/a	35-37.5	215-220
Michael Meers	Director of Information Communication and Technology	115-120	0	0-5	n/a	30-32.5	150-155
Giles Thorpe (from 23/11/2020)	Chief Nurse	40-45	100	0-5	n/a	80-82.5	125-130
Angela Tillett	Chief Medical Officer	155-160	0	n/a	10-15	40-42.5	210-215
Shane Gordon	Director of Strategy, Research and Innovation	215-220	400	0-5	n/a	0-2.5	220-225

Adrian Marr	Director of Finance	155-160	0	0-5	n/a	142.5-145	305-310
Melissa Dowdeswell (until 31/12/2020)	Interim Chief Nurse	90-95	100	n/a	n/a	12.5-15	105-110
Helen Taylor	Chair/ Non-Executive Director	55-60	0	n/a	n/a	0-2.5	55-60
Edward Bloomfield	Non-Executive Director	10-15	0	n/a	n/a	0-2.5	10-15
Hussein Khatib	Non-Executive Director	10-15	0	n/a	n/a	0-2.5	10-15
Diane Leacock (from 01/05/2020 to 31/12/2020)	Non-Executive Director	5-10	0	n/a	n/a	0-2.5	5-10
Mark Millar (from 01/01/2021)	Non-Executive Director	0-5	0	n/a	n/a	0-2.5	0-5
Elaine Noske (from 01/05/2020)	Non-Executive Director	10-15	0	n/a	n/a	0-2.5	10-15
Richard Spencer	Non-Executive Director	10-15	0	n/a	n/a	0-2.5	10-15
Carole Taylor-Brown	Non-Executive Director	10-15	0	n/a	n/a	0-2.5	10-15
Richard Youngs	Non-Executive Director	10-15	0	n/a	n/a	0-2.5	10-15
Julie Parker (left 18/06/2020)	Non-Executive Director	0-5	0	n/a	0-5	0-2.5	0-5

Pension benefits (subject to audit)

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

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 2022 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2022 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2022 £000	Cash equivalent transfer value at 31 March 2021 £000	Real increase in cash equivalent transfer value £000	Employers contributions to stakeholder pension £000
Neill Moloney	2.5-5	2.5-5	70-75	145-150	1,293	1,192	69	-
Michael Meers	7.5-10	15-17.5	55-60	125-130	1,073	902	146	-
Giles Thorpe	2.5-5	2.5-5	30-35	50-55	456	410	33	-
Angela Tillett	2.5-5	2.5-5	60-65	165-170	1,445	1,339	76	-

Please note: Nick Hulme, Shane Gordon and Adrian Marr chose not to be covered by the NHS Pension Scheme arrangements during the reporting year.

The financial information in the table above is derived from information provided to the Trust from the NHS Pensions Agency. Whilst the Trust accepts responsibility for the disclosed values, the Trust is reliant upon NHS Pensions Agency for the accuracy of the information provided to it, and has no way of auditing these figures. The figures are therefore shown in good faith as an accurate reflection of the senior managers' pensions' information. There are no entries in respect of pensions for non-executive directors as they do not receive pensionable remuneration.

The rules for the operation of the NHS Pension Scheme are set by HM Ministers under the relevant legislation. In 2015, Ministers amended the Pension Scheme Regulations to provide for a move from final salary provision to Career-Average provision, with transitional arrangements that enabled those in the final salary section to continue to accrue on that basis.

In the case of *The Lord Chancellor & Another v McCloud and others; The Home Secretary, the Welsh Ministers and others v Sargeant and others* (2018) EWCA Civ 2844, the Court of Appeal affirmed decisions of the Employment Appeals Tribunal that the relevant provisions in the pensions schemes for judicial officers and firefighters were unlawful as giving rise to age discrimination, contrary to the Equality Act 2010. It has been accepted that the relevant provisions in the NHS Pension Schemes suffer from the same defect. Since that judgement (and the subsequent refusal of leave to appeal to the UK Supreme Court), HM Government has been considering the appropriate response to these matters. It is not possible at this stage to give any view as to the possible impacts of changes that might be proposed.

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 valued are the member's 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 the 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 had 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Accounting policy for pensions can be found on page 147 of this report.

Staff report

On 31 March 2022, the Trust directly employed 11,637 staff (10,050.70 full time equivalents (FTE)).

The Trust also reviewed its acuity staffing levels on the wards, resulting in an increase in the establishment required to meet patient need safely along with additional services TUPE'd in.

	Number of Trust staff		
	Headcount	Establishment (FTE)	Staff in post (FTE)
31 March 2022	11,637	11,132	10,050.70

Staff costs (subject to audit)

	2021/22		
	Permanent (£000)	Other (£000)	Total (£000)
Salaries and wages	388,046	10,274	**398,320**
Social security costs	38,695	0	**38,695**
Apprenticeship levy	1,983	0	**1,983**
Employer contributions to NHS Pension Scheme	66,600	0	**66,600**
NEST pension contributions	131	0	**131**
Termination benefits	54	0	**54**
Agency/ bank staff	0	57,007	**57,007**
Total	**459,509**	**67,281**	**562,790**

Note: Permanent staff costs includes fixed term and seconded in staff.

Average staff numbers (subject to audit)

The average staff numbers by staff group is shown below. This calculation is based on the whole time equivalent (FTE) number of employees in each week in the financial year, divided by the number of weeks in the financial year.

Average number of employees (FTE basis)	2021/22		
	Total	Permanent	Other
Medical and dental	1,333	584	749
Administration and estates	2,679	2,341	338
Healthcare assistants and other support staff	2,136	1,766	370
Nursing, midwifery and health visiting staff	3,289	2,847	442
Scientific, therapeutic and technical staff	861	782	79
Healthcare science staff	407	373	34
General payments (non-executives)	7	7	0
Total average numbers	**10,712**	**8,700**	**2,012**

Details on staff turnover can be found on the NHS workforce statistics site, at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics.

Membership of the Trust

The data in the table below is sourced from the Trust's membership database and therefore analyses staff members, not just employees. “Staff” includes any qualifying Trust employee and hospital volunteers, so the number in the table below is greater than the number of staff employed by the Trust.

Age	Staff members 2021/22	Public members 2021/22
0 to 16 years	0	0
17 to 21 years	23	64
22+ years	10,357	9,218
Not specified	0	1,179
Total	**10,380**	**10,461**
Ethnicity		
Not specified	2,785	1,742
White	6,388	8,162
Mixed	126	102
Asian or Asian British	881	260
Black or Black British	143	137
Other ethnic group	57	58
Total	**10,380**	**10,461**
Gender		
Male	2,325	3,882
Female	8,048	6,036
Transgender	0	0
Not specified/ prefer not to say	7	543
Total	**10,380**	**10,461**

Sickness absence

Staff sickness absence	2021/22
Total WTE calendar days lost	172,314
Total WTE days available	3,550,724
Total staff years lost (days lost/365)	472.09
Total staff years available	9,728.01
Total staff employed in period*	13,181
Total staff employed in period with absence*	9,271
Total staff employed in period with no absence*	3,910
Average working days lost per employee	13.07

* Headcount, including starters and leavers. Source: Electronic Staff Record

Gender equality

A gender pay gap is the difference between the average hourly earnings of males and females, with the figure expressed as a proportion of male earnings. It is important to note that gender pay gap reporting is separate from equal pay; gender pay gap reporting requires us to publish six statutory calculations every year showing how the pay gap is between ESNEFT male and female employees.

The table below shows the breakdown of male and female executive directors, other senior managers and employees. Directors who were on interim off-payroll contracts and the non-executive directors and as at 31 March are not classed as employees and are not therefore covered in the total number of staff employed by the Trust figure of 11,637.

Role	Female	Male	Notes
Non-executive directors	2	8	Includes chair
Executive directors	1	6	Includes chief executive
Other senior managers	34	22	Bands 8d and above
Employees	9,036	2,528	
Total	**9,073**	**2,528**	

Further information is available on the ESNEFT website and for national comparison the Cabinet Office website at https://gender-pay-gap.service.gov.uk, where the Trust remains under the name of Colchester Hospital University Foundation Trust and The Ipswich Hospital.

Employment of disabled people

We are committed to eliminating discrimination, both within the workforce and in the provision of services. The Trust has a legal responsibility under the Equality Act 2010 to:

- eliminate discrimination, harassment and victimisation;
- advance equality of opportunity; and
- foster good relations between persons who share a relevant characteristic and those who do not.

Recruitment

The Trust makes sure that disabled applicants are always fully and fairly considered on their merits, as with any individual. Any applicant who meets the minimum criteria for selection is invited for interview.

Via our recruitment policy, we make sure that the implementation of the recruitment and selection practices will not discriminate directly or indirectly on the grounds of gender, sexual orientation, marriage or civil partnership, pregnancy and maternity, caring responsibility, ethnic or national origin, religion, culture, disability, age or trade union membership.

The workplace

We provide an occupational health (OH) service which can be accessed by all staff. It is delivered by a multi-disciplinary team, specialist practitioners in OH, clinical nurses, technicians and a consultant.

If an employee becomes disabled, the Trust will, via line managers and the health and wellbeing department, maintain regular contact with them to monitor progress, give support and, at an agreed and appropriate stage, consider possible courses of action. This can include a phased return to work and consideration of the effect any disability might have on future employment.

The Trust seeks to offer terms and conditions of service which will enable suitably qualified person with a disability to seek and maintain employment with the organisation wherever practicable.

Policies

We carry out equality impact assessments for equality analysis when reviewing policies or when planning changes to services as part of organisational change processes to ensure our functions and services are not discriminatory.

Training

The Trust continues to ensure that all staff have equal opportunities to develop with others, develop new skills or enhance existing skills and advance their careers. This includes mandatory training, clinical skills, personal development and apprenticeships.

We recognise that some staff will have additional needs when starting or returning to the workplace and their corporate and local induction should reflect this. This includes staff who:

- qualified abroad
- are returning to work after prolonged absence
- are training part time
- are under the age of 18
- have a disability

It is the line manager or supervisor's direct responsibility to ensure that staff with additional needs are properly inducted into the Trust and are treated equitably during their employment with the Trust.

All staff are required to undertake equality and diversity training. Compliance currently stands at 93.88%.

According to role requirements, training is also provided in the following areas:

- dementia
- deprivation of liberties
- learning disabilities
- Mental Capacity Act
- safeguarding of the vulnerable adult

The Trust has continued working with Suffolk Mind while also delivering in-house programmes to support staff health and wellbeing. We now have almost 500 mental health aiders trained and supporting colleagues across the organisation and will continue this programme throughout 2022/23.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) provides a framework for NHS trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality, and to ensure that disabled employees receive fair treatment in the workplace and have equal access to career opportunities.

The WDES is a set of 10 specific measures (metrics) which enable organisations to compare the employment experiences of disabled and non-disabled staff. From April 2019, it has applied to all NHS trusts and foundation trusts and is a key step for NHS organisations to improve equality for the workforce.

We are proud to have complied with this regulation and have developed our action plan based on our data analysis. Its goals are to:

- Create a culture and environment where ESNEFT staff are confident and empowered to disclose, as well as have, open conversations about their disability status.
- Ensure systems and processes are aligned to enable disability equality in the workplace.
- Understand and use our workforce data to inform initiatives which will improve the experience for disabled and non-disabled staff.
- Be recognised as a system leader for disability equality through wider engagement.

These goals are in alignment with NHS regulations and the Equality Act 2010. Our action plan was approved and ratified by the People and Organisational Development Committee on 26 September 2019 and published online and was updated in September 2021.

Staff engagement

Organisational development and leadership

We updated our strategy around staff experience, organisational development and leadership which was approved by our People and Organisational Development Committee and Board in June 2021.

The Trust has continued to deliver leadership training, both as a stand-alone programme and also tailored programmes for clinical leads and consultants. We have developed a set of competences for each level of leadership and management and linked these to a leadership passport and suite of training through the leadership training prospectus. We have also commissioned a specific leadership development programme for our senior leaders, and are also offering places to our system partners.

We also launched our equality diversity and inclusion strategy and ambitions in September 2021 following an extensive review with our staff governors and staff network leads.

Valuing our staff

During 2021/22, we continued to recognise staff and volunteers through our Trust commendation scheme, which gives colleagues, patients and the public the chance to nominate the people they feel have made outstanding contributions.

Everyone who is nominated receives a letter from the chief executive with the citation included. Winners are visited by a member of the executive team who presents them with their certificate.

We are continuing to celebrate the achievements of our hard working staff and this year we have particularly recognised the enormous work our staff have undertaken during COVID-19 by distributing a specially commissioned thank you badge and card to our staff from the chief executive and chairman. We will acknowledge long service once restrictions allow.

Staff Partnership Forum

The Staff Partnership Forum (SPF) is made up of management and staff side union representatives and meets monthly with the agenda agreed jointly between staff side and management.

The staff partnership agreement was reviewed and formally signed this year. It sets out the specific responsibilities and purpose of the group which, in summary, is to promote good employee relations and maintain a positive, constructive and trusting relationship between the Trust and staff side through:

- **Information**: Keeping all parties fully informed of relevant matters at the earliest opportunity. This will include the SPF receiving and discussing reports upon the Trust's planning and workforce intentions and financial position. Other relevant management issues can be raised by either party.

- **Consultation**: To be given every reasonable opportunity to provide feedback on and to be consulted upon relevant proposed management decisions, such as organisational change and non-contractual employment policies and procedures

- **Negotiation**: For the purpose of reaching agreements and avoiding disputes for matters concerning interpretation and implementation of collective agreements or contractual terms and conditions of employment.

The Trust funds 11 days a week of dedicated facility time to enable the release of the staff side chair, branch secretary and senior stewards to attend meetings, undertake specific union activity and support HR case work. Additional support from shop floor union stewards is funded by releasing staff from their substantive post. Secretarial support is provided by the HR team. Union allocation is as follows:

Role	Agreed time
Staff side chair	Four days per week
Deputy staff side chair	Two days per week
Senior steward – community	One day per week
Unison branch secretary	Three days per week
RCN lead steward	One day per week
Total dedicated time	**11 days**

Number of employees who were trade union officials	Whole time equivalents
27	24.18
Percentage of time spent on facility time	**Number of employees**
0%	26
1% - 50%	1
51% - 99%	2
100%	1
Total cost of facility time	**Costs**
Total pay bill	£562,790,000
Percentage of pay bill spent on facility time	0.02%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
649.25 hours formally recorded*	15.36%

* Due to the need to respond quickly to the pandemic a pragmatic approach to formally recording all time spent on union activity was agreed.

Freedom to Speak Up and raising concerns

Our ‘speaking up’ vision statement for the Trust is: “We encourage our staff to raise concerns openly, or anonymously if they prefer, safe in the knowledge they will be supported if they do, to make our trust a positive and trustworthy place to work and receive care.”

The vision statement encapsulates the current drive from the Board to ensure that staff at all levels of the Trust know that they will be supported if they raise a concern. We recognise that there are still individuals who struggle to make their voice heard and that some have a lack of faith that they will be listened to, or fear that they will be victimised should they do so. This is not peculiar to ESNEFT and other parts of the NHS have similar challenges, but it demands action from all of us.

We have a stand-alone page on the Trust intranet which provides all the information that an individual wishing to raise a concern, speak up or whistleblow needs. This includes pointers to potential sources of advice, policy documents that could provide guidance, websites that might be helpful and email and addresses for our Freedom to Speak Up guardian.

As part of staff induction each new employee receives a leaflet reflecting much of the advice on the intranet page, and with similar pointers to those who might help. Our raising concerns / Freedom to Speak Up policy reflects national policy and the guardian remains a member of the East of England Freedom to Speak Guardians Assembly, which is overseen by the National Guardian’s Office. The Speaking Up Safely Group encourages input from other parts of the organisation including equality and diversity and health and wellbeing. Tom Fleetwood, our Freedom to Speak Up Guardian, also regularly talks to the chief executive and chair, works with other members of the executive team, replies quarterly to the national guardian’s data collection and reports quarterly to People and Organisational Development Committee and annually to the Trust Board.

In 2021 we commissioned a specific piece of work with ‘brap’, a charity committed to transforming the way organisations think about equality. This targeted project supported one of our departments to address concerns which had been raised around discrimination and racism. brap were able to provide externality to a number of listening exercises with staff and help the Trust and division to create an action plan, which included the creation of clear behavioural expectations. In addition, we also commenced the Every Birth Every Day programme, with internal and external representation to support us to respond to recommendations from the Care Quality Commission and Ockendon Report.

NHS Staff Survey

The Trust continues to work towards the achievement of the pledges outlined in the NHS Constitution to make sure that all our colleagues feel trusted, actively listened to, provided with meaningful feedback, treated with respect at work, have the tools, training and support to deliver compassionate care and are provided with opportunities to develop and progress. This is even more critical in what have been an exceptional year for our staff. The need to support colleagues’ wellbeing, and to listen to and hear them are more important than ever.

Staff engagement

Our approach to staff engagement at ESNEFT is underpinned by six principles, embedded in our communications and engagement strategy, which was developed with our staff, partner organisations and representatives of all the communities we serve and refreshed in 2021/22.

Engaging and communicating with our staff is one of our key ESNEFT priorities. Through well-managed internal communications, we are working to deliver a common understanding of our goals and values and bring the ESNEFT brand to life through our staff. Internal communication and engagement is crucial in keeping our staff motivated, inspired and committed, and good internal communication will help retain our best staff.

We have continued to develop our response to the COVID-19 pandemic and transformed our communications with our staff, keeping a focus on timely and consistent messaging on all areas of our work while encouraging openness and feedback. The use of Teams Live events, special sessions for our staff networks, particularly our EMBRACE network, a refreshed and updated staff intranet, and an online newsletter read by up to 5,000 staff for most editions means we are reaching more staff than ever.

Internal communication and staff engagement is crucial to the success of our organisation and has a vital role to play in achieving the Trust's objectives, and to our recovery programme post COVID-19. Our monthly CEO briefings have proved popular, and from March 2020 these have been taken place through Microsoft Teams Live, with up to 750 staff joining each event and asking our CEO direct questions. During 2022, we also held virtual staff awards, with the ceremony viewed by more than 2,200 people.

Our internal communication and engagement objectives are:

- To **build** on existing staff communications channels
- To **encourage and support staff** to be part of the conversation and to share stories, ideas, successes and suggestions
- To **support leaders** across the organisation to communicate with their teams
- To **provide** clear, timely and accessible information
- To **facilitate** the development of messages, campaign assets and resources to share information

Monitoring and learning from feedback

We measure our success by delivering:

- A series of high quality internal communications and engagement methodologies that are valued by staff.
- Clarity for staff on ESNEFT's vision and strategic direction, and the ability to share and engage externally.
- Engaged, well informed and motivated staff who feel confident to be ambassadors and advocates for ESNEFT services. This is measured through the annual national NHS Staff Survey, Pulse survey and a range of other measures, working through the results of this with our staff involvement groups and developing action plans for improvement. This is led jointly between the HR team and the communications and engagement team, and monitored through the People and Organisational Development Committee

- We also monitor engagement with our various communications methodologies e.g. views of social media posts, VLOGs, live events, newsletters, views of our intranet, and report these through the executive leadership team.

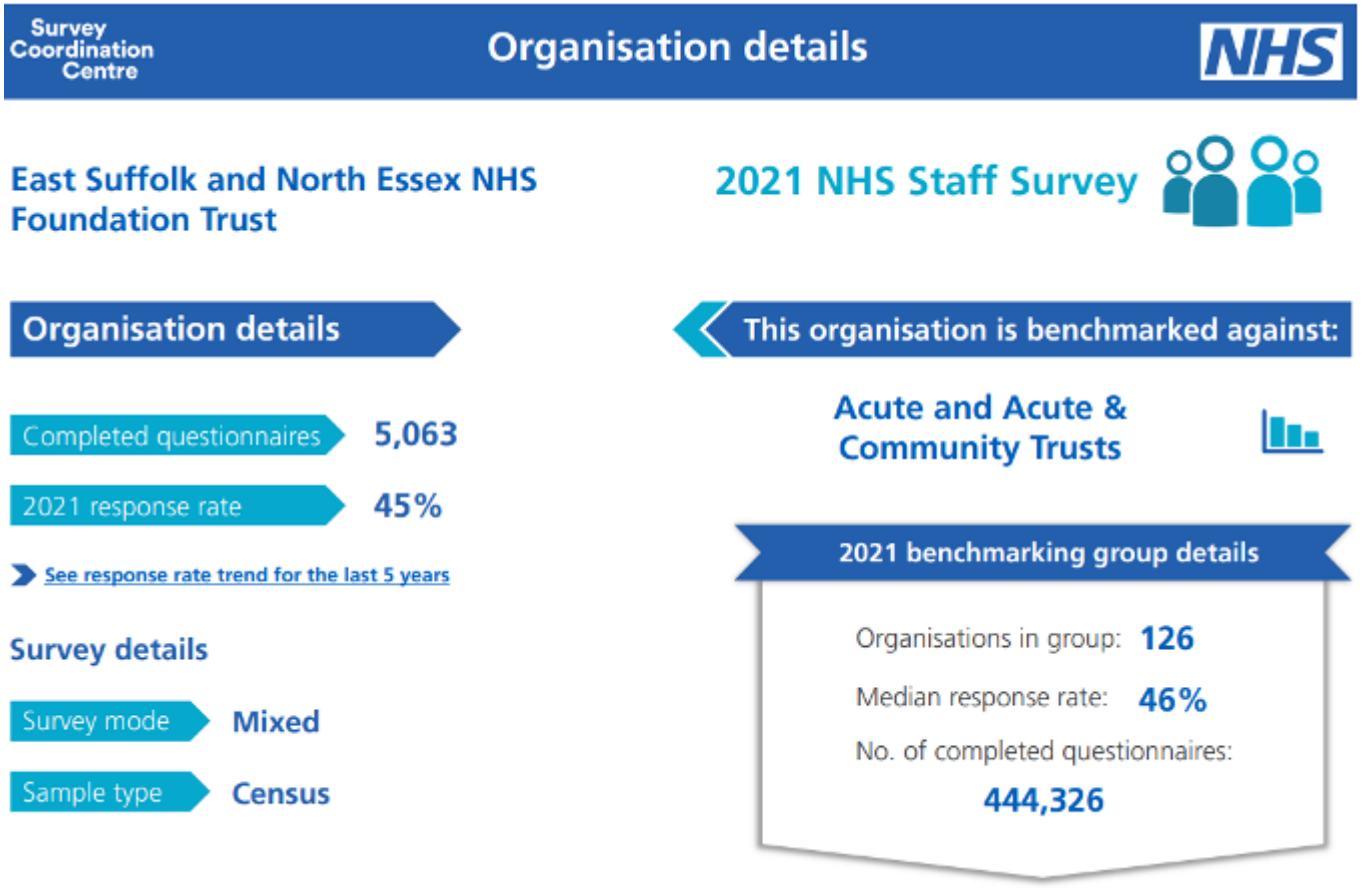
NHS Staff Survey 2021

The NHS Staff Survey is conducted annually. Our results in the 2021 NHS Staff Survey show a picture of an organisation that is improving – our scores are improved from last year in 20 areas – which, considering the strain on the organisation during COVID-19, is extremely encouraging. The full report for ESNEFT is available at www.nhsstaffsurveys.com

Our response rate to the 2021 survey was 45%, which is the equivalent of 5,063 staff. Although the percentage of staff who responded was the same as the 2020 survey, ESNEFT has had significant growth. This means that a total number of staff who responded this year increased compared to the year before.

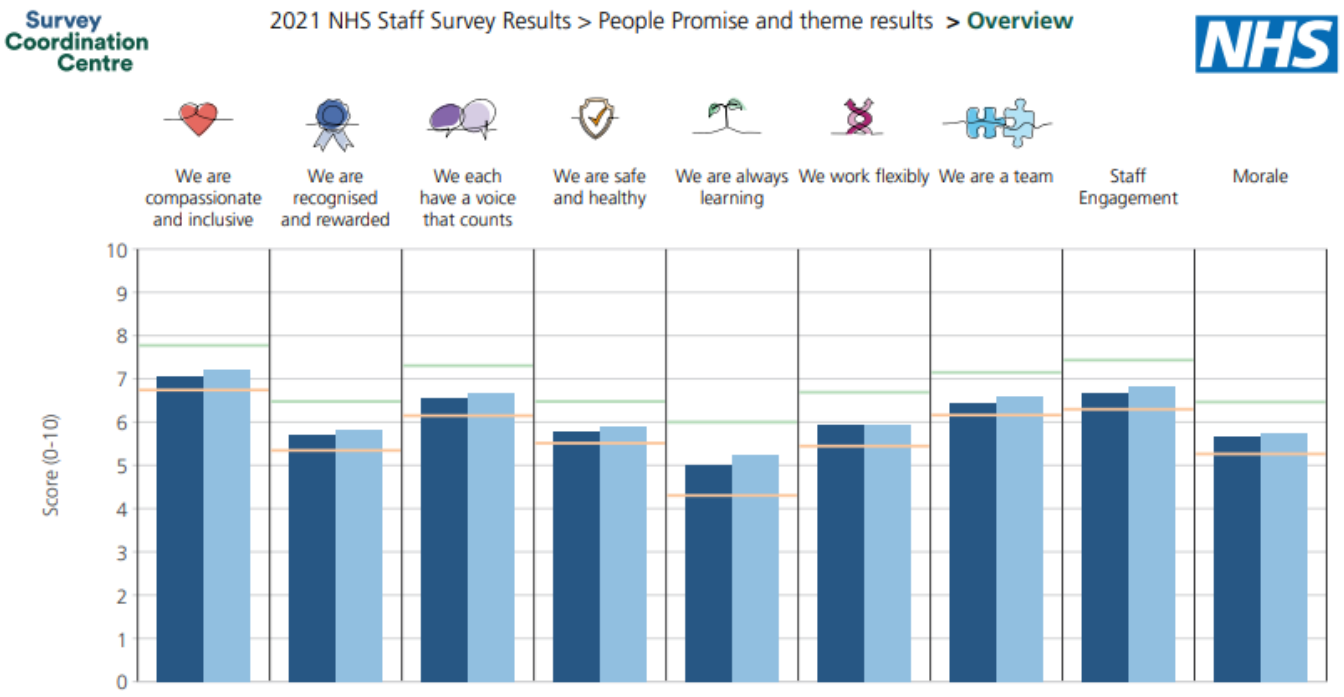
This year we worked with a new supplier and were able to see anonymised figures for where our responses were coming from. This allowed us to target support to areas where there may be fewer responses. For the first time, we are therefore able to say that ESNEFT received responses from every team in our organisation.

We were also pleased that more staff who have patient contact as part of their job completed the survey this year – 67% compared with 64% in 2020 (Q1).



The 2021 National Staff Survey looked very different to previous years as it was organised around the NHS People Promise. These are:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We always learning
- Work flexibly
- We are a team



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.7	6.5	5.8	5.0	5.9	6.5	6.7	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	5,053	5,042	5,020	5,041	4,874	5,022	5,044	5,056	5,055

The survey also included a specific section on how our staff described their experience at ESNEFT against the People Promises in relation to COVID-19. We were pleased to staff reported a 0.5% to 1.0% improvement in how they felt about support, recognition, involvement, learning opportunities, flexibility, morale, having a voice that counts and working within a safe and healthy environment.

Nationally, it has been recognised that organisations need to create a three to five year plan which addresses concerns identified by the staff survey. Our focus is on three themes – culture, leadership and involvement – which will be driven on a Trust-wide basis as well as in depth through specific activities within departments and divisions.

We have continued our drive to develop our leaders through a range of accredited programmes through which our values, philosophy and equality and inclusion are all linked. We have set specific targets around the number and level of leaders which we expect to take part in the programmes we have

designed. In addition, a suite of management and leadership apprenticeships and specialist leadership programmes have been developed and supported.

To support our focus on culture, we have commissioned a cultural audit, with an opportunity to develop our approach to zero tolerance on any form of discrimination. In addition, we have strengthened our wellbeing offer across psychology, mental, physical and financial health, and have received excellent feedback from our staff. We have also launched a staff experience group to encourage our employees to make their voices heard while providing feedback on our work around wellbeing, leadership, the employee journey, EDI and creating a just and learning culture.

Scores compared to previous year	2020	2021
Significantly better	20	4
No significant difference	52	31
Significantly worse	3	28

Most improved from last survey*	%	Change
16.c.07. On what grounds have you experienced discrimination? Other	76%	+7%
17a. I would feel secure raising concerns about unsafe clinical practice	75%	+5%
9.c. My immediate manager asks for my opinion before making decisions that affect my work	55%	+4%
7.a. The team I work in has a set of shared objectives	71%	+2%
9.a. My immediate manager encourages me at work.	68%	+2%
11.e. Have you felt pressure from your manager to come to work?	75%	+2%

* Grade based on positive responses

Least improved from last survey*	%	Change
3.i. There are enough staff at this organisation for me to do my job properly	22%	-11%
21.d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	63%	-8%
2.a. I look forward to going to work	50%	-7%
11.d. In the last three months have you ever come to work despite not feeling well enough to perform your duties?	45%	-7%
21.c. I would recommend my organisation as a place to work	54%	-7%

Our top five scores are:

1%	Q13.b In the last 12 months I have personally experienced physical violence at work from managers.
1%	Q13.c In the last 12 months I have personally experienced physical violence at work from colleagues.
3%	Q16.c.04 Experienced discrimination on grounds of sexual orientation.
4%	Q16.c.03 Experienced discrimination on grounds of religion.
7%	16.a In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public

For these scores, a lower percentage indicates a better result

Our key issues to address are:

49%	12.e I often/ always feel worn out at the end of my working day/shift.
16%	19.b The appraisal / review helped me to improve how I do my job.
43%	12.c My work often/always frustrates me.
39%	12.a I often/always find my work emotionally exhausting.
21%	5.a I have unrealistic time pressures (never/ rarely).

The responses to the three key 'recommendation' questions that indicate our overall staff engagement position in the 2021 NHS Staff Survey are outlined below:

	Q21a. Care of patients/service users is my organisation's top priority	Q21c. I would recommend my organisation as a place to work	Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation
Best	89.1%	77.6%	89.5%
ESNEFT	**70.1%**	**53.9%**	**63.0%**
Average	75.5%	58.4%	66.9%
Worst	59.4%	38.5%	43.6%

Staff Friends and Family Test

Since April 2014, the staff Friends and Family Test (FFT) has been carried out in all NHS trusts which provide acute, community, ambulance and mental health services in England.

The aim is for all staff to have the opportunity to feed back their views on their organisation at least once a year. The staff FFT is helping to promote a big cultural shift in the NHS, where staff have both the opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon.

Research has shown a relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally. It is therefore important that we strengthen the staff voice, as well as the patient voice (NHS England).

The staff friends and family test was suspended for 2021/22.

People Pulse survey

The People Pulse was officially launched in January 2022 to replace the staff Friends and Family Test. The survey is a 'temperature check' of the organisation and is not used for in depth analysis.

ESNEFT has participated since July 2021.

Review of tax arrangements of public sector appointees

The Trust now publishes information in relation to the number of off-payroll engagements following the review of tax arrangements of public sector appointees published by the Chief Secretary to the Treasury on 23 May 2012. For all off-payroll engagements the Trust follows guidance issued from NHSI.

For all off-payroll engagements as of 31 March 2022, for more than £245 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2022	1
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	1
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	15

Expenditure on consultancy

Trust expenditure on consultancy in 2021/22 was £1,796,085, up from £372,626 last year.

Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

Staff exit packages (subject to audit)

Details of compulsory redundancy payments are provided for members of staff who have been compensated due to their positions being lost as a result of departmental reorganisation or clinical service transformation.

	2021/22		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	1	17	**18**
£10,001 - £25,000	0	0	**0**
£25,001 - £50.000	0	0	**0**
£50,001 - £100,000	0	0	**0**
£100,001 - £150.000	0	0	**0**
£150,001 - £200,000	0	0	**0**
Total number of exit packages by type	**1**	**17**	**18**
Total resource cost (£000)	0	54	54

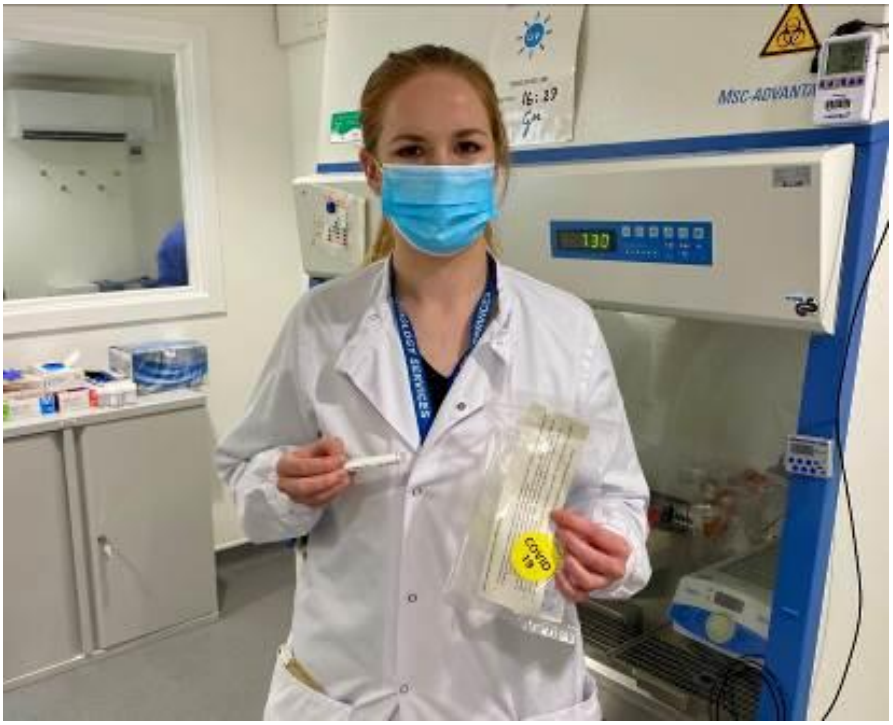
	2020/21		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	1	23	**24**
£10,001 - £25,000	0	1	**1**
£25,001 - £50.000	0	1	**1**
£50,001 - £100,000	0	0	**0**
£100,001 - £150.000	0	0	**0**
£150,001 - £200,000	1	0	**1**
Total number of exit packages by type	**2**	**25**	**27**
Total resource cost (£000)	187	94	281

This disclosure reports the number and value of exit packages agreed in the year.

Non-compulsory departure payments

	2021/22		2020/21	
	Number	Cost (£000)	Number	Cost (£000)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	17	54	25	94
Exit payments following employment tribunals or court orders	0	0	0	0
Non–contractual payments requiring HNT approval	0	0	0	0
Total	**17**	**54**	**25**	**94**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Redundancy and other departure costs have been paid in accordance with the relevant NHS provisions. Exit costs in this note are accounted for in full in the year of departure. Where the [organisation] has agreed early retirements, the additional costs are met by the [organisation] and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme are not included in the table. This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or full in a previous period.



Foundation Trust Code of Governance

East Suffolk and North Essex NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board considers that it has complied with the provisions of the NHS Foundation Trust Code of Governance during 2021/22.

Board of Directors and Council of Governors

Other disclosures relating to the Board of Directors and its committees are in the report into our Board of Directors. Disclosures relating to the Council of Governors and its committees from page 101 onwards.

Our membership

Eligibility requirements for joining different membership constituencies

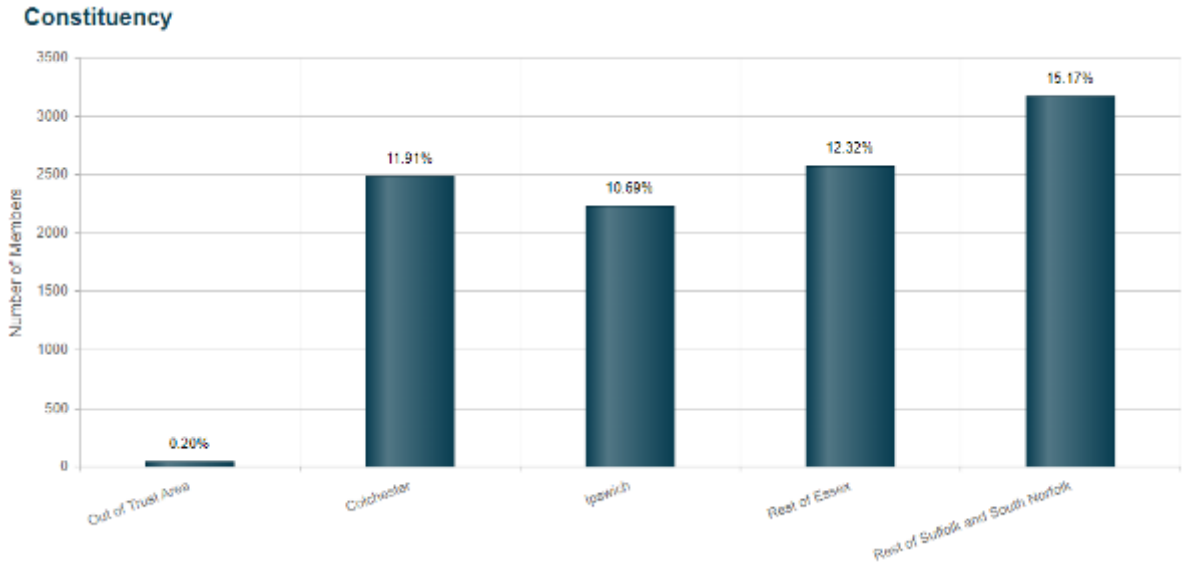
Our Trust has two types of member: public and staff. Public members are people aged 16 years or over who live in Essex or Suffolk and have registered to become a member. Staff members are automatically registered when they join the Trust and include all employees and volunteers.

The Trust's membership database is managed by an external agency and the ESNEFT membership team. Both teams remove and update membership details and contact information as required.

At March 2022, ESNEFT had 10,475 public members and 10,380 staff members.

The public members are spread across the geographical area as follows:

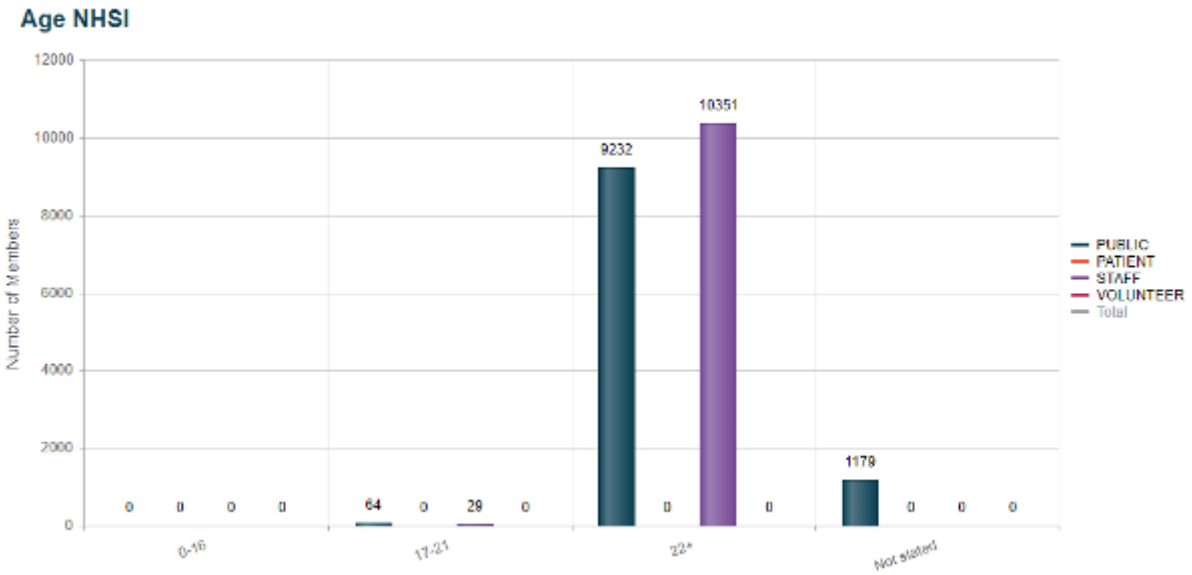
Name	Number of Members	Percentage of Members
Total Membership	**10485**	**50.28%**
Out of Trust Area	41	0.20%
Colchester	2483	11.91%
Ipswich	2229	10.69%
Rest of Essex	2569	12.32%
Rest of Suffolk and South Norfolk	3163	15.17%



Age profile of our public members

As with many NHS foundation trusts, there is under-representation of public members between the ages of 16 and 49 years. However, younger members have actively been standing for Council of Governor elections in recent years.

We have more public members aged 60 years and above than is representative of the geographical area we serve. The bars show the number of public members in each age group; to be representative of our population, we would like the bars to be the same height.



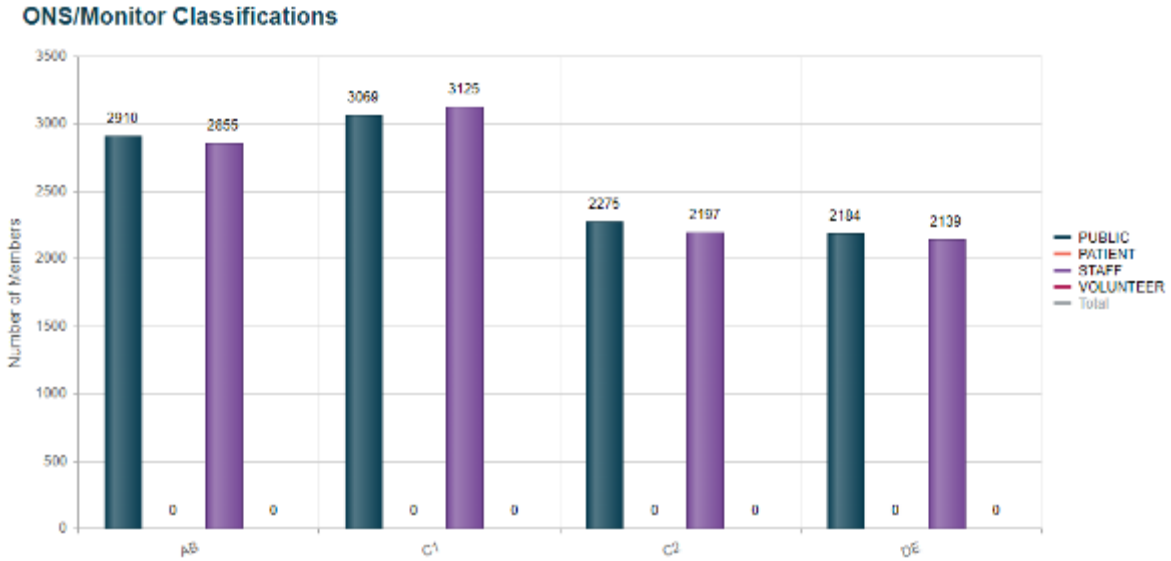
Please note that people aged under 16 are not eligible to be members. Efforts have been made below these age groups to close the under-represented age gaps.

Public membership demography

According to population data, we have far more public members than is representative in the middle class categories. In the semi and skilled labourers group, we are almost proportionately represented across all areas. Ideally, each pair of columns in the chart would be the same height to be truly representative of our population.

The National Readership Survey social grades are a system of demographic classification:

A = Higher managerial, administrative or professional
B = Intermediate managerial, administrative or professional
C1 = Supervisory or clerical and junior managerial, administrative or professional
C2 = Skilled manual workers
D = Semi-skilled and unskilled manual workers
E = Casual or lowest grade workers or those who depend on the welfare state

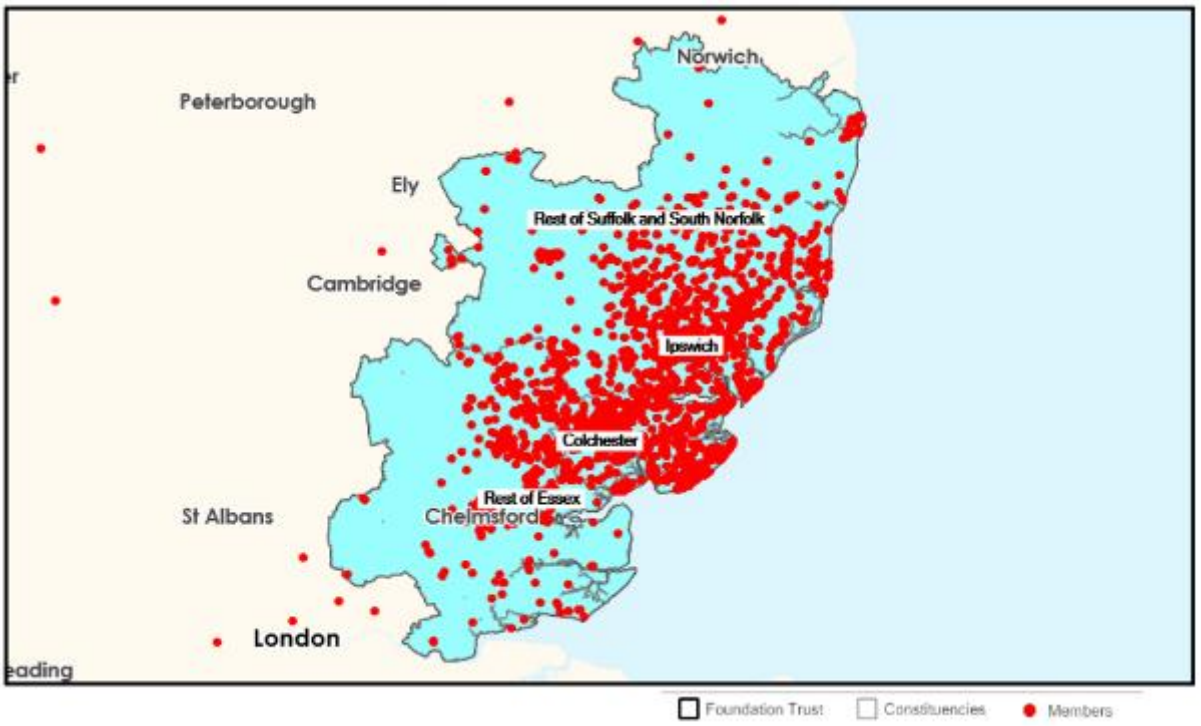


Source: Membership database managed by Civica

Location of public members

There are densely populated centres of membership at our main hospitals and community bases, including Colchester, Clacton, Harwich, Halstead, Ipswich, Felixstowe and Aldeburgh.

Some of members live outside of the blue area, which is where our external membership database team consider our boundaries to be.



Contacting our membership office

Members and the public can contact governors through the membership office by calling 01206 742347 or emailing ft.membership@esneft.nhs.uk

Council of Governors

The Council of Governors represents the interests of the public and employees through its elected governors and appointed stakeholder governors.

Directors and governors working together

The Council of Governors continues to provide an effective local accountability role for the Trust, ensuring that patients, service users, staff and stakeholders are linked in to the Trust's strategic direction. It has proved to be an effective and highly-valued critical friend of the organisation, working with the Board of Directors to develop plans for the Trust.

The Council of Governors acts as a consultative and advisory forum to the Board. It provides a steer on how the Trust can carry out its business and helps it develop long-term strategic plans consistent with the needs of the community it serves. The Council of Governors also acts as guardian to ensure that the Trust operates in a way that fits with its statement of purpose and is expected to hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors.

The other statutory duties of the Council of Governors are:

- the appointment and, if appropriate, removal of the chair and other non-executive directors
- the remuneration and allowances and other terms and conditions of office of the chair and the other non-executive directors
- the approval of the appointment of the chief executive
- the appointment and, if appropriate, removal of the auditor
- the receiving of the Trust's annual accounts, any report of the auditors on them and the annual report at a general meeting of the Council of Governors
- the approval of a significant transaction as defined in the Trust's constitution, or an application by the Trust to enter into a merger, acquisition, separation or dissolution
- a decision on whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- approval of amendments to the Trust's constitution

Membership engagement

During 2021/22, engagement with public members has been reduced due to the COVID-19 restrictions.

Our staff governors have actively promoted their role and staff wellbeing workshops, while also working with the engagement team on the outcomes on the staff survey which will continue past March 2022. Governors continued to hold virtual meetings with ESNEFT staff as a replacement to the walkabout programme. Induction and orientation has also taken place for the new governors who joined the council following the last election in summer 2021.

Seats for the constituted membership areas of the Council of Governors will be up for election in autumn 2022. Previous elections took place in summer 2018, autumn 2020 and summer 2021.

Committees and panels

There are two sub-committees of the Council of Governors: the Appointments and Performance Committee and the Standards Committee.

Governors are invited to regular informal meetings with the chair to discuss a wide range of issues, from planning and operations, through to governance and accountability arrangements relating to the Board of Directors. All of these meetings took place virtually when required.

Governors and directors are actively encouraged to attend each other's public meetings to gain insight into each other's activities and responsibilities.

During the past year, governor representatives have started attending Board assurance committees as observers once again following the merger of these committees into the Integrated Assurance Committee in 2020/21. Two governors are nominated to observe the non-executive directors carrying out their roles at each of these committees.

Standards Committee

The Standards Committee is responsible for reviewing the governors' code of conduct and enforcing it through:

- receiving and reviewing complaints and grievances against individual or groups of governors
- considering any allegations of failure by a governor to comply with the Trust's constitution or guidance issued by any regulatory authority
- assessing allegations that governors have breached the governors' code of conduct.

There were no referrals made to the Standards Committee during 2021/22 and therefore the committee did not meet.

Appointments and Performance Committee

The Appointments and Performance Committee is responsible for advising the Council of Governors on the appointment, termination, performance and remuneration of the non-executive directors (including the chair).

The committee met once in 2021/22 to review the appraisal outcomes for the non-executive directors and the Trust chair and to provide assurance to the Council of Governors on the robustness of the process.

About the governors

Elected public governors

Colchester	Ipswich
Alison Ruffell	Margaret Llewellyn
David Guest	Laurence Collins
Caroline Bowden (From 1 December 2020)	Paul Gaffney
	Tim Newton
Rest of Essex	**Rest of Suffolk**
Elizabeth Smith	Gillian Orves
Jane Young	
	John Alborough
Barry Wheatcroft (From 1 December 2020)	Philip Davy
David Gronland	Helen Rose (Lead Governor)
James Gilbert Chung	Martin Lewis Jones

Elected staff governors

Colchester and Essex	Ipswich and Suffolk
Isaac Ferneyhough	Gemma Bourne
Pride Mukungurutse	James Stephens
Sharmila Gupta	Allison Weston

Appointed stakeholder governors

Under the ESNEFT constitution, appointed governors have a fixed term of three years and a maximum of nine consecutive years.

- **Colchester Borough Council and Tendring District Council:** Cllr Lynda McWilliams was appointed in July 2021 to represent both councils.
- **Essex County Council:** Cllr Carlo Guglielmi was appointed in July 2021 for a third term of office.
- **Colchester Garrison:** Zoe Dawson-Couper was appointed in June 2020.
- **Anglia Ruskin University:** Sara Smith was appointed in July 2021.
- **Essex Healthwatch:** Sam Glover was appointed in July 2021.
- **East Suffolk District Council:** Cllr Mary Rudd was appointed in July 2021.
- **Suffolk County Council**: Cllr Rebecca Hopfensperger was appointed in July 2021.
- **University of Suffolk:** Sam Chenery Morris was appointed in July 2021.

Register of interests

All governors are asked to declare any interests on the register of governors' interests at the time of their appointment or election. This register is reviewed and maintained by the foundation trust office, and is available for inspection by members of the public. Anyone who wishes to see the register or get in touch with a governor should contact the foundation trust office by calling 01206 742347 or email ft.membership@esneft.nhs.uk

Council of Governor meetings

There were three meetings of the Council of Governors during the course of the year; held on 13 April, 3 June and 2 September 2021. The meetings were chaired by the Trust Chair, Helen Taylor. All meetings in the year were held via video conferencing as a direct response to COVID-19 pandemic.

Governor attendance at Council of Governors meetings

The table below shows attendance at meetings held between 1 April 2021 and 31 March 2022.

Name	Attended 13 April 2021	Attended 3 June 2021	Attended 2 September 2021	Total
Alison Ruffell			✓	
David Guest			✓	
Caroline Bowden	✓		✓	2/3
Paul Gaffney			✓	
Margaret Llewellyn	✓	✓	✓	3/3
Laurence Collins	✓	Apologies	✓	2/3
James Gilbert Chung			✓	
Martin Lewis Jones			✓	
Tim Newton	✓	✓	✓	3/3
Elizabeth Smith	✓	Apologies	✓	2/3
Jane Young	✓	✓	Apologies	2/3
Barry Wheatcroft	✓	Apologies	✓	2/3
David Gronland	✓	✓	✓	3/3
Gillian Orves	✓	✓	✓	3/3
Helen Rose	✓	✓	✓	3/3
John Alborough	✓	✓	Apologies	2/3
Philip Davy	✓	✓	✓	3/3
James Stephens			✓	
Sharmila Gupta	Apologies	Apologies		
Isaac Ferneyhough	✓	✓	✓	3/3
Pride Mukungurutse				
Allison Weston	✓	✓	✓	3/3
Gemma Bourne			✓	
Sam Glover				
Carlo Guglielmi	✓	✓	✓	3/3
Lynda McWilliams			✓	
Sam Chenery Morris			Apologies	
Mary Rudd			Apologies	
Zoe Dawson- Couper		✓		

Rebecca Hopfensperger			Apologies	
Chris Hall	✓	✓		
Joanne Kirchner	✓			
Paul Ellis	✓	✓	✓	
Janet Brazier	✓	✓		
David Welbourn	✓	✓		
Helen Chuah	✓	✓		
Vikki Jo Scott	✓	Apologies		
Robert Ager	✓	✓		
Deborah Potticary	✓	Apologies		
Neil MacDonald	Apologies	Apologies		
Rory Marriott	Apologies	✓		
Louise Palmer		✓		
Sara Smith			✓	

The Council of Governors did not exercise its power under the Health and Social Care Act to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties.

Regulatory ratings

NHSI Single Oversight Framework for NHS providers

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Based on the information from these themes, providers are segmented from one to four, where 'four' reflects providers receiving the most support, and 'one' reflects providers with maximum autonomy. A foundation trust will only be in segments three or four where it has been found to be in breach or suspected breach of its license.

NHS England and NHS Improvement confirm that East Suffolk and North Essex NHS Foundation Trust is in segment two for quality of care and operational performance, with no enforcement action taken by NHS Improvement.

Care Quality Commission (CQC) registration

East Suffolk and North Essex NHS Foundation Trust is registered with the CQC.

The Care Quality Commission latest planned inspection of ESNEFT services was June/July 2019 with a comprehensive review of all core services at the Ipswich Hospital site, a risk based review at Colchester Hospital site and a review of our community hospital inpatient services at Bluebird Lodge, Felixstowe Community Hospital and Aldeburgh Community Hospital.

In addition to this, a well-led review of the senior leadership team (covering the Board of Directors and the senior leadership team down to associate director level) and a use of resources assessment was undertaken by NHS Improvement.

The ESNEFT overall rating from the inspection was 'requires improvement'.

Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

The Care Quality Commission issued the trust with requirement notices in respect of:

- Regulation 11 – Need for consent;
- Regulation 12 – Safe care and treatment;
- Regulation 14 – Meeting nutritional and hydration needs; and
- Regulation 17 – Good governance

These are described as '**actions we must do**' to comply with our legal obligations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Trust has made good progress against the action plan to address the must do recommendations and reported through to the Board of Directors. As COVID-19 restrictions are reduced, audits to confirm revised systems and processes are place and working effectively will be carried out.

The full inspection report can be found at the CQC website: www.cqc.org.uk/provider/RDE

The CQC also carried out an unannounced focused inspection of the maternity services at Colchester Hospital on 30 March 2021, and at Ipswich Hospital on 7 April 2021.

Mandatory service risk

The Trust's Board of Directors is satisfied that:

- all assets needed for the provision of mandatory goods and services are protected from disposal,
- plans are in place to maintain and improve existing performance,
- the Trust has adopted organisational objectives and is now measuring performance in line with these objectives, and
- the Trust is investing in change and capital estate programmes which will improve clinical processes, efficiency and, where required, release additional capacity to ensure it meets the needs of patients.

Statement of the accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of ESNEFT

The NHS Act 2006 states that the chief executive is the accounting officer of the Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require East Suffolk and North Essex NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East Suffolk and North Essex NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- Observe the accounts direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above-mentioned act. The accounting officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Nick Hulme
Chief Executive
26 September 2022

Annual governance statement

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Suffolk and North Essex NHS Foundation Trust (ESNEFT), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at ESNEFT for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As accounting officer, I have overall responsibility for ensuring there are effective risk management systems and controls in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by NHS Improvement in respect of governance and risk management. I have delegated overall duty to ensure risk management is discharged appropriately to the chief nurse, who is responsible for the implementation of the risk management strategy.

The Board of Directors provides leadership on the overall governance agenda including risk management. It is supported by a number of committees that scrutinise and review assurance on internal control. These include:

- Audit and Risk Committee
- Integrated Assurance Committee
- People and Organisational Development Committee
- Executive Management Committee

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit and Risk Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Integrated Assurance Committee. The Board of Directors routinely receives the minutes of these committees alongside a report from the chair of the committee which highlights the key areas of discussion and any items escalated for the attention of the Board. The Board receive these alongside the Board Assurance Framework and corporate risk register.

The chief executive has overall responsibility for the management of risk. Other members of the executive team exercise lead responsibility for the specific types of risk as follows:

- The chief medical director and chief nurse are jointly responsible for clinical governance, quality and clinical risk, and whilst each have been allocated specific duties and responsibilities there are clear lines of accountability.
- The chief nurse is the executive lead for ensuring a fully integrated and joined up system of risk and control management is in place on behalf of the Board, and for the management of the Board Assurance Framework and ensuring that strategic risks are identified and reported to the Board of Directors. The chief nurse is also responsible for infection prevention and control and safeguarding children and adults.
- The managing director/ deputy chief executive, supported by the directors of operations, is responsible for the overall risks to operational performance.
- Director of finance provides the strategic lead for financial risk and the effective coordination of financial controls throughout the Trust.
- The director of workforce and organisational development is responsible for workforce planning, staffing issues, education and training and organisation development.
- The director of digital and logistics is responsible for the overall risks associated with information technology and SIRO and has responsibility for information governance.

In addition there are clear responsibilities for risk identified across the Trust. All heads of service, clinical directors and managers have delegated responsibility for the management of risk and patient safety in their areas. Risk is integral to their day-to-day management responsibilities. It is also a requirement that each division has a risk register, which is consistent and mirrors the Trust's risk register requirements, in line with the risk management strategy.

All members of staff have responsibility for participation in the risk/patient safety management system through:

- Awareness of risk assessments which have been carried out in their place of work and compliance with any control measures introduced by these risk assessments;
- Compliance with all legislation relevant to their role, including information governance requirements set locally by the Trust;
- Following all Trust policies and procedures;
- Reporting all adverse incidents and near misses via the Trust incident reporting system;
- Attending regular training as required ensuring safe working practices;
- Awareness of the Trust patient safety and risk management strategy and their own patient safety and risk management process; and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Trust recognises the importance of supporting staff through appropriate training, development and access to systems. The quality and patient safety team support staff who are undertaking risk assessments and managing risk as part of their role. Risk assessment training is available to all members of staff and includes:

- Corporate induction training when staff join the Trust;
- Mandatory update training for all staff at specified intervals;
- Targeted training with specific areas including risk assessment, incident reporting and incident investigation; and
- Training and mentoring support for the electronic adverse event reporting system that is targeted at managers of wards, departments and non-clinical areas.

The Board has set out the minimum requirements for staff training required to control key risks through a clear mandatory training programme including infection control, fire safety, safeguarding adults and children, information governance and manual handling. During 2021/22 we achieved 86.3% compliance

against this programme despite the restrictions of the pandemic. The mandatory training framework describes the requirements for each staff group and the frequency of training in each case. In addition, incident investigation training is available, which covers documentation, root cause analysis, serious incidents and steps to prevent or minimise recurrence and report requirements.

Incidents, complaints and patient feedback are routinely analysed to identify learning opportunities and improve control and are reported to the Board through the Integrated Assurance Committee. Lessons learnt are disseminated to staff using a variety of methods.

The Trust has in place counter fraud arrangements through RSM from the NHS Counter Fraud Authority and has a named local counter fraud specialist. In order to ensure counter fraud resources are effective, there is a counter fraud plan and annual report which outlines the proactive, reactive and strategic counter fraud work undertaken for the Trust in 2021/22.

I have ensured that all significant risks of which I have become aware of are reported through to the Board of Directors. All new significant risks escalated to me as chief executive and the executive team. The Trust's principal and strategic risks are captured in the Board Assurance Framework and corporate risk register, which is used to inform the risk priorities of the Board and the assurance committees (for 2021/22 the Audit and Risk Committee and Integrated Assurance Committee). The Audit and Risk Committee has a further duty to review the Trust's internal financial controls and the Trust's internal control and risk management systems.

The risk and control framework

The Trust has a risk management strategy (titled 'the risk management policy'), which is reviewed and endorsed by the Board of Directors. It provides a clear, systematic approach to the management of risks to ensure that risk assessments are an integral part of clinical, managerial and financial processes the organisation.

The strategy sets out the role of the Board and its committees together with individual responsibilities of the chief executive, executive directors, and other senior managers and all staff in managing risk. It assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. All risks are evaluated against a common grading matrix to ensure that all risks are considered alike. The control measures designed to mitigate and minimise identified risk, are recorded within the risk register and Board Assurance Framework.

The Board Assurance Framework sets out:

- What the organisation aims to deliver (strategic objectives);
- Factors which could prevent those objectives being achieved (strategic risks);
- Processes in place to manage those risks (controls);
- The extent to which the controls will reduce the likelihood of a risk occurring;
- The evidence that appropriate controls are in place and operating effectively (assurance); and
- Risk rating pre and post mitigation and target rating.

The Board Assurance Framework provides assurance to the Board that these risks are being adequately controlled and informs the preparation of the annual governance statement. The Board Assurance Framework was reviewed regularly during the year by the Board and its committees and did not identify any significant gaps in control/ assurance.

In 2019/20 the Trust approved its five year strategy and has worked to develop supporting enabling strategies and the identification of principal risks that may prevent the achievement of the strategic

objectives. A new Board Assurance Framework to cover the principal risks, key controls, gaps in control, gaps in assurance, movements in the risk profile and actions to reduce risks to an acceptable level was established in 2020/21.

The Board has considered and agreed the principles regarding the risk that the Trust is prepared to seek, accept or tolerate in the pursuit of its objectives and has captured these in its risk appetite statement.

In order to be assured, the Board has engaged the internal auditors to carry out checks and outcomes, which are fed back to the Board of Directors through a chair's key issue report via the Audit and Risk Committee.

The Trust had planned to carry out a self-assessment to assess its leadership against the NHSI Well-Led Framework. This was deferred to 2022/23 due to the restrictions in place to manage COVID-19.

The Board completed their annual self-declaration against the fit and proper persons test in March 2021. There are robust arrangements in place for any new starter to the Board. The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively. The chair and non-executive directors have a broad base of skills and experience and each non-executive director brings individual skills and personal experience including financial, healthcare and commercial.

The risk appetite statement is incorporated in the Trust's risk management policy.

During 2021/22, the Trust saw its principal risks as follows:

- A failure to deliver the fundamental standards of care and reduce unwanted variation across all settings in the Trust, caused by inconsistent processes and practice, may lead to poorer patient experience and suboptimal clinical outcomes. This, in turn, may lead to increased regulatory scrutiny, reputational damage, financial cost through litigation, and a potential negative impact on the recruitment and retention of staff and students.

- Quality governance – if the Trust does not continue to have robust oversight of quality outcomes and improvements through a clearly defined quality governance framework, this may lead to key issues and risks not being identified early, which will prevent the Trust reacting effectively and efficiently, thereby minimising the opportunity to avoid harm and poor patient and staff experience. This, in turn, may lead to increased regulatory scrutiny and associated issues.

- Staff engagement – if we do not engage the ESNEFT workforce and make staff aware of the Trust's priorities and values, there may be an impact on staff morale, productivity and potential for reputational damage.

- Long term financial sustainability – if we do not establish systematic processes for identifying, measuring and delivering cost improvement opportunities and leveraging transformational change, then we will not deliver the cost improvement programme in the financial year or create long term opportunities for sustainability. This may lead to failure to deliver the control total, impact on cash flow and long-term sustainability as a going concern.

- Maternity – insufficient midwifery staffing may lead to unfilled shifts and potential for poor patient experience.

- Transformation – if we do not transform through strategy and its delivery then we will be unable to achieve long term sustainability leading to regulator intervention.

- Financial management – if we do not have effective organisational financial management in place, then we may not be able to fully mitigate the variance and volatility in financial

performance against the plan leading to failure to deliver the control total, impact on cash flow and long-term sustainability as a going concern.

- Recruitment and retention – if we do not have a clear plan to support and develop our staff, improve recruitment and retention, grow our substantive workforce and strengthen staff engagement, leadership and culture across the Trust, then we will not achieve our ambitions.

- COVID-19 recovery – if we do not effectively plan to recover nor have the workforce and services that meet the need of the local population during and post COVID-19, this may lead to prolonged waiting times and system wide pressures, together with offering mutual aid across the integrated care system (ICS), which may give rise to suboptimal outcomes for patients.

- Emergency, preparedness, resilience and response (EPRR) – if we do not have in place appropriate EPRR to business disruption then there may be continued disruption to clinical and corporate services which may lead to patient care being suboptimal.

- IT disruption outage – if we are not able to respond effectively to potential IT disruption outage/ incident, then there will be delays on clinical and corporate services operational and transformational delivery.

- Estates maintenance and development – if we do not have agreed future models of care or the capital investment to deliver the ESNEFT estates strategy to provide a safe, compliant and functionally suitable environment for patients, visitors and staff this will impact our ability to deliver the overall Trust strategy and ICS objectives.

- Investment in IT – if investment to support IT strategy delivery is not available then there could be delay to the delivery of enabling programmes of work to support the delivery of the Trust strategy.

These risk issues, the key controls in place to manage them and the actions in hand to further reduce their likelihood and impact were discussed at deep dive sessions and reported to the Board. During the year, the potential impacts of these risks to the achievement of the Trust's strategy has been reviewed by the Board, supported by the executive team, as further evidence became available; for example, the Board gave further consideration to the risks related to maternity services with the publication of the final Ockenden report with recommendations to be considered by all maternity providers. Similar processes have been undertaken to provide assurance to the Board regarding the effectiveness of the planned management and mitigation measures for the identified risks, reflecting changes in evidence and the environment in which the Trust operates.

Risks are identified through many sources such as risk assessments, clinical benchmarking, audit data, clinical and non-clinical incident reporting, complaints, claims, patient and public feedback, stakeholder and partnership feedback and internal/ external assessment, including CQC inspection reports.

Risks to compliance with Condition FT4 of the Trust's provider licence have been considered in connection with the annual compliance declaration required by that Licence. Key risks identified, and the mitigations in place, are:

- **Governance structures proving ineffective** – mitigated by regular reviews, clear lines of reporting, forward planning of expected business for consideration, and the forthcoming well-led review by an external agency. Further mitigations include the ability of individuals to raise concerns through the Freedom to Speak Up guardian and similar mechanisms.

- **Flows of information to Board and Board Committees are ineffective** – mitigated by clear lines of responsibility, written terms of reference and executive director responsibilities, triangulation by non-executive directors through formal and informal contacts, feedback from the

Council of Governors on concerns raised by their constituents, feedback through the Freedom to Speak Up process.

Care Quality Commission registration requirements

The Care Quality Commission's (CQC) last planned inspection of ESNEFT's services took place in June/July 2019. This included a comprehensive review of all core services at the Ipswich Hospital site, a risk based review at Colchester Hospital and a review of inpatient services at Bluebird Lodge, Felixstowe Community Hospital and Aldeburgh Community Hospital. Our overall rating following the inspection was 'requires improvement'.

In February 2021, maternity services at both Colchester and Ipswich hospitals were inspected by the CQC and rated 'requires improvement'.

We have launched a major maternity improvement programme at our Trust called Every Birth Every Day, which focuses on delivering great care to families and newborn babies. Membership includes community representatives and members of the Maternity Voices Partnership, which represents the views and experiences of pregnant people and their families, while the programme is chaired by our chief executive.

The programme concentrates on all aspects of safety and makes sure anyone using our maternity services has a positive experience with us. We also have a strengthened maternity leadership team in place, which provides consistent oversight of the standards of care for pregnant people, their babies and families.

We are making significant progress on all the recommendations for change, not only those made by the Care Quality Commission, but also the interim and final Ockenden reports. We take the recommendations extremely seriously and are working with our partners across the Suffolk and North East Essex Integrated Care System to improve our services further.

The focus for us at ESNEFT in the coming months is the continued recruitment of maternity and obstetric staff. We have already had success in this area, with new staff joining the Trust following both national and international recruitment campaigns.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

Performance information

The Board reviews performance data each month against NHS Improvement and CQC standards and outcomes via the integrated performance report focusing on key performance indicators of quality, safety, patient experience and clinical outcomes, people and organisational development and finance.

The Trust adopts a bottom-up approach to performance management which includes monthly performance review meetings with each division. During the review meetings members of the divisional leadership present their performance and risk positions for scrutiny by the executive team.

Incident reporting

Incident reporting and investigation is recognised as a vital component of risk and safety managements and is key to being a learning organisation. The Trust has an electronic incident reporting system, accessible to all colleagues. Incident reporting is promoted through induction and training programs, regular communications, patient safety walk rounds and peer reviews and inspections. There is an escalation process for incidents and the executive team are alerted when a new incident is reported.

- Adverse incident reporting – ESNEFT promotes a culture of openness and transparency and staff are advised on the Trust's approach to this through the being open/ duty of candour policy.
- Serious incident reporting – A director-led assurance panel reviews the reports from serious incidents to ensure that actions taken are embedded and effective. Learning from these is reported to the Board quarterly via the Quality and Safety Committee.
- Never events – details of never events can be found elsewhere in the annual report.
- Claims – The Trust has robust processes in place for dealing with both clinical negligence and employers liability claims. A summary of any settled claim is disseminated where appropriate to:
    - involved clinician(s)
    - relevant clinical director
    - directors
    - quality and safety team

At ESNEFT, we believe that every incident offers an opportunity to learn. The reporting of incidents is a fundamental building block in achieving an open, transparent way of fulfilling this aim, without fear. Our structures and frameworks promote learning, escalation, treatment and mitigation of, or from, risk.

Staffing

The Trust has in place effective systems and processes which assure the Board that staffing is safe, sustainable and effective, ensures provision of a quality service and that care and treatment needs are met. The Trust reviews it staffing establishments in line with National Quality Board guidance, assessing that the right number and skill mix of staff are available to meet the needs of people using the service. This review includes use of evidence-based tools where available, such as the safer nursing care tool, national guidance, reviews of quality measure and outcomes and professional judgement.

We have an electronic roster system in place for nursing staff which details the type and number of staff that are required to ensure there are suitably qualified, competent, skilled and experienced staff to meet patients' care and treatment needs effectively. We work in partnership with bank and agency providers to fill gaps in our rotas. We have commenced a piece of work to review acuity and skill mix for medical staff.

Professional teams carry out daily staffing reviews (risk assessments) in line with standard operating procedure. These take into account staff numbers, skill mix and competencies, patient acuity and dependency and activity. Where indicated, staff are used flexibly to provide cover and any risks are formally escalated for action to the staffing coordinator, while the senior manager on call is also informed. Where such mitigations are insufficient to address the gap, business continuity plans are enacted with escalation to the director on call. In response to operational demands from COVID-19, an additional strategic workforce group (chaired by the director of people and organisational development) was established to coordinate all workforce responsive actions including volunteers.

The Trust has an agreed set of workforce performance metrics which are RAG-rated against expected performance. These are reported to the Board of Directors within the monthly integrated performance report. Where a metric is below target, remedial actions are included in the report and, where necessary, overseen by a Board assurance committee and reported to the Board through an integrated performance report.

ESNEFT's nursing and midwifery establishment and skill mix review was presented to the Board of Directors, which included recommendations from the chief nurse to ensure safe and effective staffing. We have also reviewed medical staffing levels to improve sustainability of medical cover. Rotas for trainee doctors across the Trust are monitored for compliance, with oversight from the Guardian of Safe Working whose work is overseen by the People and Organisational Development Committee. All changes to skill mix and introduction of new roles undergo a quality impact assessment which is signed off by the chief nurse and chief medical officer.

ESNEFT has an annual workforce plan which is submitted to the Board of Directors and NHSI on an annual basis, in line with guidance. The Trust is currently developing it medium and long term workforce strategy.

System oversight framework

Following a consultation period, NHSE/I have now published updated oversight arrangements: the System Oversight Framework 2021/22. The proposals are designed to strengthen the system-led delivery of integrated care. They include a framework based on five national themes (not CQC domains, but broadly aligned to these) that reflect the ambitions of the NHS Long Term Plan and apply across providers, commissioners and ICSs:

1) quality of care, access and outcomes;
2) preventing ill health and reducing inequalities;
3) people;
4) finance and use of resources; and
5) leadership and capability.

There is also a sixth theme based on local strategic priorities.

Following consideration by the NHSEI regional support group, it has been agreed that Suffolk and North East Essex ICS should be placed into SOF segment two, which is defined as an ICS on a development journey, demonstrating many of the characteristics of an effective, self-standing ICS. The regional team will work with the Trust to access flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (e.g. GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via the regional improvement hubs.

Cost improvement plans (CIP)

To deliver the financial improvement trajectory, a cost improvement programme of £15.7m needs to be delivered which may be in the form of planned cost reductions, as set out at the start of the financial year, or through cost avoidance, which may be necessary to mitigate any underachievement of the plan during the year. Recognising the size of the cost reductions, the Trust is gearing up robust measures for monitoring and in particular escalation and recovery arrangements to mitigate slippage of delivery, particularly during the transition phase.

Stakeholders

Public stakeholders are involved in the management of risks which impact on them through meetings of the Board held in public, and our attendance at health overview and scrutiny meetings. Governors are involved in discussions about risks which impact on patients and members through regular meetings of the Council of Governors and governor sub-groups and their attendance as observers at Board sub-committees. They are involved in the development of the Trust's strategy and operational plans. Our engagement with our stakeholders produces an additional layer of scrutiny and challenge from broad representative areas of our population groups and therefore enables the Trust to remain grounded and responsive to the communities we serve.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular through the work of the Suffolk and North Essex Integrated Care System.

Further information regarding patient and public engagement in the Trust is included elsewhere in this annual report.

Register of gifts and hospitality

The Trust has published an up-to-date register of interests for decision-making staff (as defined by the Trust in accordance with the guidance) within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The Trust continues to champion the process and embed within the organisation.

The register can be accessed on the Trust website at www.esneft.nhs.uk/about-us/annual-report-and-accounts/esneft-register-of-interests/

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and human rights

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. This includes carrying out equality impact assessments to provide assurance that consultations relating to changes to any of our functions and services are not discriminatory. Where any remedial action is identified by the assessment, we develop and implement an action plan to address this.

Climate change

The Trust has undertaken risk assessments, and has plans in place, which take account of the 'Delivering a Net Zero Health Service' report under the 'Greener NHS' programme. The Trust ensures that its obligations under the Climate Change Act and the adaption reporting requirements are complied with.

Corporate governance statement

The Trust's risk and governance frameworks as described in this statement ensure that the organisation can confirm the validity of its corporate governance statement as required under NHS foundation trust condition 4(8)(b). The Trust's executive team carries out regular risk assessments of its compliance with these conditions and flags for the Board's attention those areas where action is required. The corporate governance statement itself, with a summary of the evidence supporting it, is reviewed by the Board of Directors.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has a range of processes in place to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff, regular reporting to the Board on quality, operational performance and finance, with further review and scrutiny on a monthly basis at meetings of the Integrated Assurance Committee.

The Trust has an agreed risk-based annual audit programme with its internal auditors. These audit reports are aimed at evaluating the Trust's effectiveness in operating in an efficient and effective manner and are focused on reviewing its operational arrangements for securing best value and optimum use of resources in respect of the services the organisation provides.

For 2021/22 the Trust incurred a deficit of £5.6 million. This includes a significant impairment of assets of £12.6 million. NHSI/E measure the Trust's financial performance after adjusting for certain items, such as impairments and donated income. On this measure, the Trust delivered a surplus of £8.2 million.

To deliver this financial position, cost improvement savings of £18.0m were delivered.

The Trust has continued to seek economy, efficiency and effectiveness in the use of resources, particularly with regard to its decision-making processes and sustainable resource deployment. The merger and the immediate post-merger implementation programme, along with the implementation of tighter management and control over quality, operational efficiency and finance has strengthened the Board's confidence in the Trust's strategy and operational delivery.

Information governance

The director of ICT and logistics is the Trust's designated senior information risk owner (SIRO) who has responsibility for data security as the champion for information risk. The SIRO aims to mirror the model prescribed by central Government's Cabinet Office. Following this best practice approach allows for uniformity across the public sector as it strives to meet the competing demands of further transparency and public/private engagement in contrast to increased cybersecurity threats and the need to prevent data leakage. By treating information as a business priority and not as an ICT or technical issue, the Trust can ensure that risks are addressed, managed and capitalised upon.

The Trust currently reports key IT controls relating to data and cyber security to the e-Health Group. We also act on any advice from the NHS Digital CareCert information sharing portal on cyber security, and have increased our cyber security precautions by appointing a dedicated IT security manager who is a certified information systems security professional. We have reported no significant cyber security incidents in the past year.

Information governance incidents are captured through the Trust's incident reporting system, Datix. Incidents are reviewed by the data protection officer, and where serious incidents are identified the incidents are scored in accordance with the NHS Digital Checklist 'Guidance for Reporting, Managing and Investigation Information Governance and Cyber Security Incidents Requiring Investigation'. The data protection officer has investigated 265 potential personal data breaches, two of which were reportable to the Information Commissioner's Office (ICO). The ICO was satisfied with our investigation and response, therefore no further action was taken in these cases.

Data Protection Act subject access requests are managed in accordance with GDPR. Staff training is aligned with General Data Protection Act and Information Governance Freedom of Information Act.

Following the suspension of information governance mandatory training to refocus on priorities associated with the response to COVID-19, the Trust is continuing to meet two of the mandated standards, and its self-assessment with standards not fully met (plan agreed).

Data quality and governance

ESNEFT places high priority on the quality of its clinical outcomes, patient safety and patient experience and strives to deliver the principles outlined in NHSI's Well-Led Framework.

To support the executive team, all aspects of quality governance report through the Patient Safety Group, Patient Experience Group and the Clinical Effectiveness Group, with escalation through to the Executive Management Committee.

These indicators have been incorporated into the key performance indicators reported regularly to the Board as part of the performance monitoring arrangements. Scrutiny of the information contained within these indicators and its implication as regards to clinical outcomes, patient safety and patient experience takes place at the Integrated Assurance Committee.

The inter-relationship between the indicators for the quality report and other measures of the Trust's performance (financial and operational) is reviewed monthly by the Board of Directors. Reviews of data quality and the accuracy, validity and completeness of Trust information fall within the remit of the Audit and Risk Committee, which is informed by the reviews of internal and external audit and internal management assurances.

The Trust assures the quality and accuracy of its elective waiting time data through a regular validation process internally, with additional checks by the business informatics team to ensure the data reported is accurate. This includes ensuring all 52-week breaches have been confirmed by the service, with large movements checked and triangulated with other recording systems. Further independent assurances are made through internal audits of data quality, national validation programmes and third party support from specialist organisations with validation expertise.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Assurance Committee and other assurance committees of the Board, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed.

The Trust Board seeks assurance from the Trust's internal auditors, by way of reports that are published in response to reviews initiated following the agreement of an annual audit plan.

These reports are undertaken in accordance with the requirements of the Public Sector Internal Audit Standards and provide specific levels of assurance and include suggested actions to improve controls where this is considered necessary.

Apart from the Audit and Risk Committee, other sub-committees include the Integrated Assurance Committee and People and Organisational Development Committee, details of which are set out in the accountability report section of this annual report.

The Audit and Risk Committee provides the Trust Board with a means of independent and objective review of:

- internal control
- financial systems
- the financial information used by the Trust
- controls assurance systems

- risk management systems
- compliance with law, guidance and codes of conduct

The Audit and Risk Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Board has also benefited from the advice and input of the Patient Safety Committee, which has responsibility on behalf of the Board for monitoring issues related to quality and safety of the services provided to patients. This has conducted a number of 'deep dive' reviews during the course of the year into key areas, which have given the Board positive assurance regarding the controls in place.

Internal audit

The Trust benefits from an internal audit arrangement provided through RSM, an external firm. The internal audit provider attends meetings of the Audit and Risk Committee as a matter of course, and has direct access to myself as the accounting officer and to the chair of the Audit and Risk Committee in the event that this is considered necessary.

We have received the Head of Internal Audit Opinion which has expressed that the Trust has a positive level of assurance through its control systems:

> "The Trust has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

During the course of the year, the internal audit service has issued eight reports, in accordance with the plan agreed with the Audit Committee. These reports, and the levels of assurance reported, were as follows:

Budgetary control	Substantial assurance
Divisional governance – Community Division	Reasonable assurance
Divisional governance – IT Division	Reasonable assurance
Divisional governance – Women's and Children's Division	Partial assurance
Medical Devices Management	Minimal assurance
Medicines Management (stage one)	Substantial assurance
Payroll	Reasonable assurance
The People Plan	Substantial assurance

During the year, the internal audit service issued one report finding minimal assurance, in respect of the controls in place for medical devices management. The key control weaknesses identified in the review were-

- A lack of a plan or process to align process across the Trust, which were still operating the separate processes from prior to merger.
- The Trust's medical devices management policy was not reflective of practice on the ground/ was not being implemented. Similarly, more detailed procedures were of varying quality and effectiveness.
- There was not a single system being used to identify assets, manage their maintenance and record their disposal.
- There were significant issues with recording the maintenance and existence of assets.

An action plan was prepared in response to the findings, and was considered by the Audit Committee; implementation and completion was monitored closely through the course of the year. Most actions have been progressed in accordance with the timeframes agreed by the Audit Committee, while some actions have had the timeframes reviewed and new targets agreed by the committee, reflecting other operational pressures. Progress against targets has also been monitored regularly by the internal audit service, as part of their regular reporting to the committee on the progress against agreed actions from their reports.

All reviews by internal audit, and the actions recommended, are reported to the Audit and Risk Committee for consideration. Progress against the agreed actions are regularly monitored by the committee to ensure that they are being implemented appropriately and in a timely way.

External audit

External audit provides independent assurance on the accounts, annual report and annual governance statement. These documents and internal and external audits of specific areas of internal control provide the Board of Directors with the information it requires to gain assurance that the Trust is meeting its objectives to protect patients, staff, the public and other stakeholders against risks of any kind; which allows the Board to support me in signing this annual governance statement.

In accordance with the relevant legislation, the Trust's external auditors are appointed by the Council of Governors. BDO LLP have been appointed by the council to provide this service. Appropriate arrangements are in place to ensure that no conflicts of interest arise from their provision of audit services and any other services provided to the Trust in which they may be interested.

As is usual practice, the final stages of the external audit process for the year and the issue of the audit opinion will follow the approval of this statement. At the approval of this statement, the external auditors have not indicated any significant concerns which might cause them to qualify their audit opinion.

Conclusion

The system of internal control has been in place in East Suffolk and North Essex NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

In summary, I am assured that the NHS foundation trust has an overall sound system of internal controls in place which is designed to manage the key organisational objectives and minimise the NHS foundation trust's exposure to risk. There are however weaknesses in the system which are being addressed. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

I am assured that:

- The Board, executive directors and senior management have identified and are managing the risks facing the Trust, with the escalation of risk events, an effective process for keeping risks scores up to date and flagging any risk and control concerns.

- There is an appropriate risk management framework embedded in the Trust.

- The internal auditors and other independent assurance providers to the Trust, including external audit, have identified no major concerns from their risk focused programme of independent assurance.

My review therefore confirms no significant internal control issues have been identified for the year ended 31 March 2022.

Nick Hulme
Chief Executive
26 September 2022

Independent auditor's report to ESNEFT's Council of Governors

Opinion on financial statements

We have audited the financial statements of East Suffolk and North Essex NHS Foundation Trust (the Trust) for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs), and as interpreted and adapted by the 2021/22 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2021/22, and the NHS Foundation Trust Annual Reporting Manual 2021/22 issued by NHS Improvement.

In our opinion the financial statements:

- give a true and fair view of the financial position of East Suffolk and North Essex NHS Foundation Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2021/22; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the accounting officer with respect to going concern are described in the relevant sections of this report.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the remuneration report and staff report

We have also audited the information in the remuneration report and staff report that is subject to audit, being described in that report as audited.

In our opinion the parts of the remuneration report and staff report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have completed our work on the Trust's arrangements. On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2022.

We have reported the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the auditor's annual report.

Responsibilities of the accounting officer

The accounting officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice we report to you if:

- in our opinion, the annual governance statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with our knowledge acquired in the course of the audit; or
- we refer a matter to the regulator under Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under Schedule 10 of the National Health Service Act.

We have nothing to report in these respects.

Responsibilities of the directors and the accountable officer

As explained more fully in the statement of directors' responsibilities in respect of the accounts, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Our procedures included the following:

- inquiring of management, the Trust's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's policies and procedures relating to:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Trust's controls relating to Managing Public Money requirements;
- discussing among the engagement team and involving relevant internal specialists, including information technology specialists, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, posting of unusual journals and cut off of and recognition of expenditure around the year-end;
- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. Relevant laws and regulations identified include VAT legislation and PAYE legislation, and the NHS Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit Committee and in-house legal counsel concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantively testing an increased sample of expenditure around the year end.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it. A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

As set out in the 'other matters on which we report by exception' section of our report there are certain other matters which we are required to report by exception.

Certificate

We certify that we have completed the audit of East Suffolk and North Essex NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of East Suffolk and North Essex NHS Foundation Trust, as a body, in accordance with Schedule 10 of the National Health Service Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Council of Governors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

DocuSigned by:
David Eagles
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David Eagles
Partner

For and on behalf of **BDO LLP**
Statutory Auditor
Ipswich UK

26 September 2022

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

Annual Accounts

For the year ended 31 March 2022

Foreword to the accounts

These accounts, for the year ended 31 March 2022, have been prepared by East Suffolk and North Essex NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Nick Hulme
Chief Executive
26 September 2022

Statement of comprehensive income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	891,494	739,959
Other operating income	4	69,629	116,522
Operating expenses	6.1	(957,794)	(849,177)
Operating surplus from continuing operations		**3,329**	**7,304**
Finance income		101	9
Finance expenses		(2,559)	(3,327)
PDC dividends payable		(6,525)	(4,851)
Net finance costs		**(8,983)**	**(8,169)**
Gains arising from transfers by absorption	27	22	318
Deficit for the year		**(5,632)**	**(547)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(19,491)
Revaluations		10,120	5,015
Other reserve movements		-	4
Total comprehensive income / (expense) for the year		**4,488**	**(15,019)**

Statement of financial position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets		10,369	10,819
Property, plant and equipment	11.1	370,747	321,574
Receivables	14.1	2,416	2,346
Total non-current assets		**383,532**	**334,739**
Current assets			
Inventories		11,974	10,907
Receivables	14.1	30,634	23,101
Non-current assets for sale	15	1,947	1,947
Cash and cash equivalents	16.1	99,655	106,381
Total current assets		**144,210**	**142,336**
Current liabilities			
Trade and other payables	17	(133,259)	(120,901)
Borrowings	19.1	(5,735)	(4,008)
Provisions	21.1	(1,223)	(4,057)
Other liabilities	18	(2,333)	(1,947)
Total current liabilities		**(142,550)**	**(130,913)**
Total assets less current liabilities		**385,192**	**346,162**
Non-current liabilities			
Borrowings	19.1	(41,304)	(48,683)
Provisions	21.1	(4,719)	(2,639)
Other liabilities	18	(977)	(1,302)
Total non-current liabilities		**(47,000)**	**(52,624)**
Total assets employed		**338,192**	**293,538**
Financed by			
Public dividend capital		385,614	345,448
Revaluation reserve		33,093	23,048
Other reserves		754	754
Income and expenditure reserve		(81,269)	(75,712)
Total taxpayers' equity		**338,192**	**293,538**

The notes on pages 135 to 161 form part of these accounts.

Nick Hulme
Chief Executive
26 September 2022

Statement of changes in equity for the year ended 31 March 2022

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2021	**345,448**	**23,048**	**754**	**(75,712)**	**293,538**
Deficit for the year	-	-	-	(5,632)	(5,632)
Revaluations	-	10,120	-	-	10,120
Transfer to retained earnings on disposal of assets	-	(75)	-	75	-
Public dividend capital received	40,166	-	-	-	40,166
Taxpayers' equity at 31 March 2022	**385,614**	**33,093**	**754**	**(81,269)**	**338,192**

Statement of changes in equity for the year ended 31 March 2021

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2020	**124,708**	**37,640**	**754**	**(75,285)**	**87,817**
Deficit for the year	-	-	-	(547)	(547)
Impairments		(19,491)			(19,491)
Revaluations	-	5,015	-	-	5,015
Transfer to retained earnings on disposal of assets	-	(116)	-	116	-
Public dividend capital received	220,740	-	-	-	220,740
Other reserve movements	-	-	-	4	4
Taxpayers' equity at 31 March 2021	**345,448**	**23,048**	**754**	**(75,712)**	**293,538**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves represents the balance of working capital inventories, and plant and equipment assets transferred to the Trust as part of the disaggregation and dissolution of Essex and Herts Community Trust in 2001. The reserve is held in perpetuity.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of cash flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		3,329	7,304
Non-cash income and expense:			
Depreciation and amortisation	6.1	21,596	19,282
Net impairments	7	12,591	2,903
Income recognised in respect of capital donations	4	(188)	(1,342)
Losses from disposal of property, plant and equipment		741	1,304
Amortisation of PFI deferred credit		(326)	(326)
(Increase) / decrease in receivables and other assets		(9,266)	58,530
(Increase) / decrease in inventories		(1,067)	105
Increase in payables and other liabilities		5,160	32,952
Increase / (decrease) in provisions		(741)	2,764
Other movements in operating cash flows		563	171
Net cash flows from operating activities		**32,392**	**123,647**
Cash flows from investing activities			
Interest received		60	9
Purchase of intangible assets		(2,922)	(3,655)
Purchase of property, plant and equipment		(62,906)	(46,488)
Sales of property, plant and equipment		172	2,200
Prepayment of PFI capital contributions		-	(511)
Net cash flows used in investing activities		**(65,596)**	**(48,445)**
Cash flows from financing activities			
Public dividend capital received		40,166	220,740
Loans repaid to the Department of Health and Social Care		(3,341)	(193,869)
Other loans received		144	210
Other loans repaid		(141)	(81)
Capital element of finance lease rental payments		(1,614)	(1,682)
Capital element of PFI and other service concession payments		(1,163)	(1,123)
Interest on loans		(304)	(883)
Other interest		-	(9)
Interest paid on finance lease liabilities		(900)	(1,049)
Interest paid on PFI and other service concession obligations		(1,780)	(1,936)
PDC dividend paid		(4,589)	(6,395)
Net cash flows from financing activities		**26,478**	**13,923**
Increase / (decrease) in cash and cash equivalents		**(6,726)**	**89,125**
Cash and cash equivalents at 1 April - brought forward		**106,381**	**17,256**
Cash and cash equivalents at 31 March	16.1	**99,655**	**106,381**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case. In coming to this conclusion, we have considered opening cash balances, revenue and capital funding streams for the coming year and our exposure to loan facilities which need to be repaid. In light of these considerations, and having made appropriate enquiries, the Directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

Note 1.3 Interests in other entities
The Trust has not consolidated the activities of the East Suffolk and North Essex NHS Foundation Trust Charitable Fund, whose activities are not considered to be material.

Note 1.4 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office for National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year-end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Suffolk and North East Essex Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed. The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue for education and training
The Trust also receives funding from Health Education England for training and education, which is accounted for under IFRS15, and recognised when the training/activity takes place.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by

employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.7.2 Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as "held for sale"; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying

assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.7.5 Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	10	65
Plant and machinery	5	15
Transport equipment	7	7
Information technology	3	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial assets and financial liabilities

Note 1.9.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Note 1.9.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
The Trust's financial assets comprise cash and cash equivalents, and contract and other receivables. All financial assets are in a business model whose objective is to hold the financial asset in order to collect contractual cash flows and the contractual terms of the financial assets give rise to cash flows that are solely payments of principal and interest. They are initially recognised at fair value plus transaction costs and are subsequently carried at amortised cost using the effective interest rate method, less provision for impairment.

The Trust's financial liabilities comprise trade and other payables, obligations under PFI and lease arrangements and loan payables. All financial liabilities are neither held for trading nor have they been designated at fair value through profit or loss, as such they qualify for measurement at amortised cost. Financial liabilities are initially measured at fair value plus transaction costs and are subsequently measured at amortised cost using the effective interest rate method.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or

expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost, including lease receivables and contract receivables, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract, other receivables, and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.9.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.10 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.10.1 The Trust as a lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.10.2 The Trust as a lessor

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.11 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities except for:

- donated assets (including lottery funded assets)
- average daily cash balances held within the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable

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

Note 1.12 Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.13 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.14 Transfers of functions from other NHS bodies
For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities. An equivalent entry is recorded against Public Dividend Capital to reflect this net gain / loss in the Trust's taxpayer's equity.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts. Further details of absorption gains can be found at note 27.

Note 1.15 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease. On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard to existing operating leases without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short-term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	57,577
Additional lease obligations recognised for existing operating leases	(57,423)
Changes to other statement of financial position line items (excluding reserves)	(154)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(7,120)
Additional finance costs on lease liabilities	(517)
Lease rentals no longer charged to operating expenditure	7,400
Estimated impact on Statement of Comprehensive Income in 2022/23	**(237)**
Estimated increase in capital additions for new leases commencing in 2022/23	**3,116**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to the retail price index. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified as HM Treasury has not yet issued guidance on the application of IFRS 16 liability measurement principles to IFRIC 12 liabilities.

Note 1.16 Critical judgements in applying accounting policies

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

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

Property, plant and equipment valuation

Critical judgements have been applied in accounting for specialised buildings specifically in relation to the valuation assumptions.

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore, the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

In determining the MEA, the Trust has to make assumptions that are practically achievable, however, the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because the chosen locations and the catchment areas for patients using the Trust's services has been taken into account when deciding on appropriate alternative sites.

The Trust does not intend to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for both Colchester Hospital and Ipswich Hospital would be a multi-storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, under-utilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

The MEA valuations used by the Trust have been provided to the Trust by the Valuation Office Agency. The Trust has used component lives based upon contractual information provided by the Valuation Office Agency to depreciate buildings and dwellings on a component basis.

Non consolidation of charitable funds
International Accounting Standard number 27 (IFRS10) requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS10 defines a subsidiary as an entity that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities. The Trust is corporate trustee of the charitable fund and meets the definition of control.

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

The net assets of the charitable fund are less than 3% of the Trust's net assets. Charitable income is less than 0.5% of Trust income. The directors therefore consider that the significant amount of work which would be necessary to consolidate the accounts of the charitable fund with those of the Trust is not justified on the grounds of materiality.

Note 1.17 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property, plant and equipment valuation
The Trust considers that the valuation of property, plant and equipment assets poses a significant risk relating to estimates and assumptions about their carrying value. To mitigate the risk of material misstatement, the Trust engages the professional services and advice of a professional RICS qualified valuer as detailed in note 13. The qualified valuer is recognised as a suitable provider of a range of valuation and surveying services to public sector bodies and their estimates can be relied upon in respect of these services, including estimates of the remaining useful economic lives of property assets.

The key assumptions that are most likely to affect the valuations are:

Cost data: The valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the valuer relies on indices that are informed through the Building Cost Information Service (BCIS) all in tender price index, which provides statistical data across a wide range of buildings and more accurately reflects tender levels in the industry. The BCIS and location factor for the alternative site are applied to the costs associated with the construction of the Modern Equivalent Asset and allows the costs to be adjusted to the valuation date. The Trust requires asset valuations at a given valuation date for accounting purposes and the valuer assists in providing these asset valuations having regard to the forecast tender cost information available at the time. However, the final BCIS figure does not become fixed until some 6 to 9 months after the relevant calendar valuation date which could give rise to some variation to the values reported at the valuation date. As an illustration of this for the Colchester Hospital site, if the BCIS were 5% higher this would have an impact on the value of specialised properties recorded in the Statement of Financial Performance of an increase of £6.3 million.

Gross Internal Area (GIA): The GIA of the Trust's buildings is a key valuation characteristic of the overall asset value as the BCIS and location factor for the alternative site are applied to GIA figures in estimating the costs associated with the construction of the Modern Equivalent Asset. As the Trust has assumed that its modern equivalent assets would occupy less land and has not included unused space, unused land, under-utilised space or any space not used for healthcare purposes or required to directly support the delivery of healthcare, any variation in the GIA could lead to differences in the values reported at the valuation date. As an example, for the Colchester Hospital site, the Trust currently assumes an overall reduction in GIA of 15% for its modern equivalent asset. If this percentage was decreased to 10% this would have an impact on the value of specialised properties recorded in the Statement of Financial Performance of an increase of £8.0 million.

The valuer also reviewed the useful economic lives of the Trust buildings. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of remaining useful economic lives by category of an asset are detailed in note 1.7.5.

Note 2 Operating segments
The Trust has determined that the chief operating decision maker is the Board of Directors, on the basis that all strategic decisions are made by the Board. Segmental information is not provided to the Board of Directors and therefore it has been determined that there is only one business segment, that of healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	789,923	693,092
High cost drugs income from commissioners (excluding pass-through costs)	47,055	20,357
Other NHS clinical income	2,375	4,308
Clinical partnerships providing mandatory services (including S75 agreements)	12,017	-
All services		
Private patient income	1,643	1,000
Elective Recovery Fund	14,151	-
Additional pension contribution central funding*	20,203	18,306
Other clinical income	4,127	2,896
Total income from activities	**891,494**	**739,959**

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2021/22 £000	2020/21 £000
Income from patient care activities received from:		
NHS England	130,247	125,687
Clinical commissioning groups	752,963	606,078
Other NHS providers	2,375	4,308
NHS other	139	-
Local authorities	12	-
Non-NHS: private patients	1,643	1,000
Non-NHS: overseas patients (chargeable to patient)	99	107
Injury cost recovery scheme	1,120	326
Non NHS: other	2,896	2,453
Total income from activities	**891,494**	**739,959**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22 £000	2020/21 £000
Income recognised this year	99	107
Cash payments received in-year	31	90
Amounts added to provision for impairment of receivables	143	104
Amounts written off in-year	17	210

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Other operating income from contracts with customers						
Research and development	1,162	-	**1,162**	495	-	**495**
Education and training	24,632	-	**24,632**	23,785	-	**23,785**
Non-patient care services to other bodies	5,248	-	**5,248**	4,600	-	**4,600**
Reimbursement and top up funding	9,522	-	**9,522**	56,649	-	**56,649**
Income in respect of employee benefits accounted on a gross basis	3,022	-	**3,022**	2,889	-	**2,889**
Car parking income	1,754	-	**1,754**	754	-	**754**
Pharmacy sales	2,171	-	**2,171**	2,051	-	**2,051**
Staff contribution to employee benefit schemes	996	-	**996**	1,330	-	**1,330**
Restaurant sales	863	-	**863**	760	-	**760**
Facilities management services	763	-	**763**	751	-	**751**
Crèche services	624	-	**624**	558	-	**558**
Other non-contract operating income						
Gains on disposal of property, plant and equipment	-	144	**144**	-	18	**18**
Education and training - notional income from apprenticeship fund	-	930	**930**	-	697	**697**
Receipt of capital grants and donations						
Donations of physical assets from NHS charities	-	188	**188**	-	126	**126**
Donated equipment from DHSC for COVID-19 response	-	-	**-**	-	1,216	**1,216**
Charitable and other contributions to expenditure						
Received from NHS charities	-	595	**595**	-	433	**433**
Equipment and consumables donated from DHSC for COVID-19 response	-	2,214	**2,214**	-	12,061	**12,061**
Rental revenue from operating leases	-	803	**803**	-	810	**810**
Amortisation of PFI deferred income / credits	-	326	**326**	-	326	**326**
Other income	13,672	-	**13,672**	6,213	-	**6,213**
Total other operating income	**64,429**	**5,200**	**69,629**	**100,835**	**15,687**	**116,522**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end is £1.621m.

Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods is nil.

Note 5.2 Transaction price allocated to remaining performance obligations
Revenue from existing contracts allocated to remaining performance obligations is nil.

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services
Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	851,370	717,757
Income from services not designated as commissioner requested services	40,124	22,202
Total	**891,494**	**739,959**

Note 6.1 Operating expenses

	2021/22 £000	2020/21 £000
Purchase of healthcare from NHS and DHSC bodies	8,672	8,560
Purchase of healthcare from non-NHS and non-DHSC bodies	33,539	28,117
Staff and executive directors costs	562,442	504,964
Remuneration of non-executive directors	267	215
Supplies and services - clinical (excluding drugs costs)	85,417	78,386
Supplies and services - general	21,879	23,999
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	81,639	69,143
Inventories written down	101	448
Consultancy costs	557	373
Establishment	9,787	8,472
Premises - business rates collected by local authorities	2,381	2,171
Premises – other	41,818	37,998
Transport (business travel only)	1,302	857
Transport - other (including patient travel)	599	365
Depreciation on property, plant and equipment	18,774	16,997
Amortisation on intangible assets	2,822	2,285
Net impairments	12,591	2,903
Loss on disposal of property, plant and equipment	885	1,322
Movement in credit loss allowance: contract receivables	(945)	551
Increase/(decrease) in other provisions	(399)	3,553
Change in provisions discount rate(s)	27	42
Fees payable to the external auditor:		
Audit services - statutory audit *	118	94
Internal audit costs	79	79
Clinical negligence	25,795	24,865
Legal fees	610	395
Insurance	932	727
Research and development	3,756	-
Education and training	7,107	3,285
Rentals under operating leases	8,033	7,042
Redundancy	-	184
Charges to operating expenditure for on-SoFP PFI schemes	856	936
Recruitment fees	506	163
Grants	6,102	2,680
Professional services	14,103	10,174
Licence fees	512	296
Car parking & security	623	140
Hospitality	23	8
Losses, ex gratia & special payments	42	39
Other services, e.g. external payroll	484	69
Other	3,958	6,280
Total	**957,794**	**849,177**

* Audit fees are disclosed inclusive of VAT.

Note 6.2 Other auditor remuneration
Other remuneration paid to the external auditor was nil (2020/21: nil).

Note 6.3 Limitation on auditor's liability
The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus resulting from:		
Changes in market price	12,591	2,903
Total net impairments charged to operating surplus	**12,591**	**2,903**
Impairments charged to the revaluation reserve	-	19,491
Total net impairments	**12,591**	**22,394**

The impairments recognised in 2020/21 and 2021/22 are the result of the revaluation of the Trust's building assets.

Note 8 Employee benefits

	2021/22 £000	2020/21 £000
Salaries and wages	398,320	354,367
Social security costs	38,695	34,184
Apprenticeship levy	1,983	1,749
Employer's contributions to NHS pensions	66,600	60,898
Pension cost - other	131	94
Early termination benefits	54	-
Temporary staff (including agency)	57,007	53,810
Total staff costs	**562,790**	**505,102**
Of which		
Costs capitalised as part of assets	348	138

Note 8.1 Retirements due to ill health

During 2021/22 there were two early retirements from the Trust agreed on the grounds of ill health (four in the year ended 31 March 2021). The estimated additional pension liabilities of these ill health retirements is £66k (£144k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

The Trust offers two pension schemes to staff, the NHS pension scheme and the National Employment Savings Trust (NEST).

NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022 is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

NEST

The Pensions Act 2008 and 2011 automatic enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Pension Scheme, the Trust used an alternative pension scheme called NEST to fulfil its automatic enrolment obligations. NEST is a defined contribution pension scheme established by law to support the introduction of auto enrolment. Contributions are taken from qualifying earnings, which for the tax year 2021/22 were £6,240 up to £50,270. Total contributions are 8%, with employee contributions at 4%, employer contributions at 3% and government contributions (tax relief) at 1%. More details on NEST can be found on the NEST website www.nestpensions.org.uk.

Note 10 Operating leases

Note 10.1 The Trust as a lessor

This note discloses income generated in operating lease agreements where East Suffolk and North Essex NHS Foundation Trust is the lessor.

The Trust's operating lease income is from the annual rents charged by the Trust for the use of its premises. Lease income from operating leases is recognised in income on a straight-line basis over the lease term, irrespective of when the payments are due.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	803	810
Total	**803**	**810**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due on land leases:		
- not later than one year;	207	184
- later than one year and not later than five years;	699	565
- later than five years.	3,755	3,741
Total	**4,661**	**4,490**
Future minimum lease receipts due on building leases:		
- not later than one year;	599	619
- later than one year and not later than five years;	2,174	2,292
- later than five years.	9,305	9,772
Total	**12,079**	**12,683**
Total future minimum lease receipts due:		
- not later than one year;	806	803
- later than one year and not later than five years;	2,873	2,857
- later than five years.	13,061	13,513
Total	**16,740**	**17,173**

Note 10.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East Suffolk and North Essex NHS Foundation Trust is the lessee.

The Trust's operating leases include rentals for the use of NHS premises, lease car contracts and the hire of medical and laboratory equipment. The leases have been reviewed and classified as operating leases in accordance with IAS17.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	8,033	7,042
Total	**8,033**	**7,042**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due on building leases:		
- not later than one year;	6,458	3,720
- later than one year and not later than five years;	20,882	9,573
- later than five years.	21,368	13,533
Total	**48,708**	**26,826**
Future minimum lease payments due on other leases:		
- not later than one year;	854	894
- later than one year and not later than five years;	834	649
- later than five years.	-	-
Total	**1,688**	**1,543**
Future minimum lease payments due:		
- not later than one year;	7,312	4,614
- later than one year and not later than five years;	21,716	10,222
- later than five years.	21,368	13,533
Total	**50,396**	**28,369**

Note 11.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021	**18,550**	**219,357**	**32,238**	**102,076**	**-**	**13,274**	**-**	**385,495**
Transfers by absorption	-	-	-	31	-	(5)	-	**26**
Additions	-	744	62,615	7,873	-	77	-	**71,309**
Impairments	-	(15,499)	-	-	-	-	-	**(15,499)**
Revaluations	950	4,322	-	-	-	-	-	**5,272**
Reclassifications	-	25,541	(35,608)	8,055	18	1,994	-	**-**
Disposals / derecognition	-	-	-	(7,976)	-	(679)	-	**(8,655)**
Valuation/gross cost at 31 March 2022	**19,500**	**234,465**	**59,245**	**110,059**	**18**	**14,661**	**-**	**437,948**
Accumulated depreciation at 1 April 2021	**-**	**-**	**-**	**55,362**	**-**	**8,559**	**-**	**63,921**
Transfers by absorption	-	-	-	3	-	1	-	**4**
Provided during the year	-	7,756	-	9,421	-	1,597	-	**18,774**
Impairments	-	(2,908)	-	-	-	-	-	**(2,908)**
Revaluations	-	(4,848)	-	-	-	-	-	**(4,848)**
Disposals / derecognition	-	-	-	(7,063)	-	(679)	-	**(7,742)**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**57,723**	**-**	**9,478**	**-**	**67,201**
Net book value at 31 March 2022	**19,500**	**234,465**	**59,245**	**52,336**	**18**	**5,183**	**-**	**370,747**
Net book value at 1 April 2021	**18,550**	**219,357**	**32,238**	**46,714**	**-**	**4,715**	**-**	**321,574**

Note 11.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020	**18,550**	**226,333**	**10,916**	**91,429**	**-**	**11,551**	**1,760**	**360,539**
Transfers by absorption	-	151	-	772	-	14	-	**937**
Additions	-	417	40,729	17,934	-	833	-	**59,913**
Impairments	-	(25,291)	-	-	-	-	-	**(25,291)**
Reclassifications	-	17,747	(19,407)	(445)	-	2,105	-	**-**
Disposals / derecognition	-	-	-	(7,614)	-	(1,229)	(1,760)	**(10,603)**
Valuation/gross cost at 31 March 2021	**18,550**	**219,357**	**32,238**	**102,076**	**-**	**13,274**	**-**	**385,495**
Accumulated depreciation at 1 April 2020	**-**	**-**	**-**	**54,167**	**-**	**8,455**	**1,384**	**64,006**
Transfers by absorption	-	86	-	525	-	8	-	**619**
Provided during the year	-	7,826	-	7,722	-	1,325	124	**16,997**
Impairments	-	(2,897)	-	-	-	-	-	**(2,897)**
Revaluations	-	(5,015)	-	-	-	-	-	**(5,015)**
Disposals / derecognition	-	-	-	(7,052)	-	(1,229)	(1,508)	**(9,789)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**55,362**	**-**	**8,559**	**-**	**63,921**
Net book value at 31 March 2021	**18,550**	**219,357**	**32,238**	**46,714**	**-**	**4,715**	**-**	**321,574**
Net book value at 1 April 2020	**18,550**	**226,333**	**10,916**	**37,262**	**-**	**3,096**	**376**	**296,533**

Note 11.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & equipment	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022							
Owned - purchased	19,500	193,658	59,245	47,914	18	5,183	**325,518**
Finance leased	-	7,194	-	3,208	-	-	**10,402**
On-SoFP PFI contracts and other service concession arrangements	-	31,058	-	-	-	-	**31,058**
Owned – donated/granted	-	2,555	-	1,214	-	-	**3,769**
NBV total at 31 March 2022	**19,500**	**234,465**	**59,245**	**52,336**	**18**	**5,183**	**370,747**

Note 11.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & equipment	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	18,550	180,615	32,238	40,384	-	4,710	**276,497**
Finance leased	-	6,948	-	4,406	-	-	**11,354**
On-SoFP PFI contracts and other service concession arrangements	-	29,358	-	-	-	-	**29,358**
Owned – donated/granted	-	2,436	-	1,924	-	5	**4,365**
NBV total at 31 March 2021	**18,550**	**219,357**	**32,238**	**46,714**	**-**	**4,715**	**321,574**

Note 12 Donations of property, plant and equipment

The Trust received donated equipment from the East Suffolk and North Essex NHS Foundation Trust Charitable Fund valued at £188k (2020/21: £126k, along with £1,216k of items centrally procured by DHSC to support COVID).

Note 13 Revaluations of property, plant and equipment

In accordance with IAS 16, all property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at current value. All land and buildings are restated to current value using professional valuations at least every five years, with an interim valuation at 3 years. All plant and equipment, transport equipment and information technology is valued using a depreciated historical costs basis as a proxy for current value.

For land and building assets, professional valuations are carried out by the District Valuer Service of the Valuation Office Agency. The valuations have been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant Department of Health and Social Care Group Accounting Manual. They are also prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation - Global Standards and RICS UK National Supplement, commonly known together as the Red Book, in so far as these are consistent with IFRS and the aforementioned guidance; RICS UK VPGA 5 refers.

The valuation basis for the Trust's land and building assets is that of an alternative site basis. In selecting the alternative site on which the modern equivalent asset would be situated, the Valuer, in discussion with the Trust, considers whether the actual site remains appropriate for use by the Trust, in accordance with section 7 of UK GN on DRC. For public sector bodies, HM Treasury guidance is that the choice of whether to value an alternative site will normally hinge on whether the proposed alternative site will meet the locational requirements of the service that is being provided.

A valuation of land and buildings was prepared by the District Valuer Service as at 31 March 2022 based on a desktop update with no site inspections undertaken due to COVID-19. This resulted in a downward revaluation of buildings by £2.471m. £12.591m of this value was an impairment charged to operating expenses with the other £10.120m being an increase to the revaluation reserve.

Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. In accordance with Treasury guidance, all revaluations undertaken since 1 May 2008 (Colchester) and 1 July 2018 (Ipswich) have been based on "modern equivalent assets".

Note 14.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	19,634	16,811
Allowance for impaired contract receivables	(2,415)	(4,364)
Prepayments (non-PFI)	7,061	3,829
PFI lifecycle prepayments	2,271	2,190
Interest receivable	41	-
PDC dividend receivable	-	1,785
VAT receivable	3,988	2,186
Other receivables	54	664
Total current receivables	**30,634**	**23,101**
Non-current		
Contract receivables	1,327	1,468
Allowance for impaired contract receivables	(298)	(292)
Other receivables	1,387	1,170
Total non-current receivables	**2,416**	**2,346**
Of which receivable from NHS and DHSC group bodies:		
Current	10,028	9,813
Non-current	1,387	1,170

Note 14.2 Exposure to credit risk

The Trust has no significant exposure to credit risk as the majority of the Trust's revenue comes from contracts with other NHS bodies.

Note 15 Non-current assets held for sale

	2021/22 £000	2020/21 £000
NBV of non-current assets for sale at 1 April	**1,947**	**4,100**
Assets sold in year	-	(2,153)
NBV of non-current assets for sale at 31 March	**1,947**	**1,947**

Note 16.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22 £000	2020/21 £000
At 1 April	**106,381**	**17,256**
Net change in year	(6,726)	89,125
At 31 March	**99,655**	**106,381**
Broken down into:		
Cash at commercial banks and in hand	35	35
Cash with the Government Banking Service	99,620	106,346
Total cash and cash equivalents as in SoFP	**99,655**	**106,381**

Note 16.2 Third party assets held by the Trust

East Suffolk and North Essex NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 22 £000	31 March 2021 £000
Monies on deposit	26	180
Total third party assets	**26**	**180**

Note 17 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	22,263	28,752
Capital payables	30,860	23,426
Accruals	69,016	59,141
Receipts in advance and payments on account	26	-
Other taxes payable	10,943	9,402
PDC dividend payable	151	-
Other payables	-	180
Total current trade and other payables	**133,259**	**120,901**
Of which payables from NHS and DHSC group bodies:		
Current	9,984	14,269

Note 18 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	2,007	1,621
Deferred PFI credits / income	326	326
Total other current liabilities	**2,333**	**1,947**
Non-current		
Deferred PFI credits / income	977	1,302
Total other non-current liabilities	**977**	**1,302**

Note 19.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	3,046	1,199
Other loans	141	85
Obligations under finance leases	1,343	1,561
Obligations under PFI or other service concession contracts	1,205	1,163
Total current borrowings	**5,735**	**4,008**
Non-current		
Loans from DHSC	11,902	17,090
Other loans	314	367
Obligations under finance leases	13,055	13,988
Obligations under PFI or other service concession contracts	16,033	17,238
Total non-current borrowings	**41,304**	**48,683**

Note 19.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Finance leases	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**18,289**	**452**	**15,549**	**18,401**	**52,691**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,341)	3	(1,614)	(1,163)	**(6,115)**
Financing cash flows - payments of interest	(304)	-	(900)	(660)	**(1,864)**
Non-cash movements:					
Additions	-	-	312	-	**312**
Application of effective interest rate	304	-	487	660	**1,451**
Other changes	-	-	564	-	**564**
Carrying value at 31 March 2022	**14,948**	**455**	**14,398**	**17,238**	**47,039**

Note 19.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**212,711**	**322**	**17,298**	**19,524**	**249,855**
Cash movements:					
Financing cash flows - payments and receipts of principal	(193,869)	129	(1,682)	(1,123)	**(196,545)**
Financing cash flows - payments of interest	(883)	-	(1,049)	(700)	**(2,632)**
Non-cash movements:					
Additions	-	-	122	-	**122**
Application of effective interest rate	330	-	1,207	700	**2,237**
Other changes	-	1	(347)	-	**(346)**
Carrying value at 31 March 2021	**18,289**	**452**	**15,549**	**18,401**	**52,691**

Note 20 Finance leases

East Suffolk and North Essex NHS Foundation Trust as a lessee
Obligations under finance leases where the Trust is the lessee.

	31 March 2022 £000	31 March 2021 £000
Gross lease liabilities	**22,366**	**24,232**
Of which liabilities are due:		
- not later than one year;	2,223	2,503
- later than one year and not later than five years;	7,265	8,217
- later than five years.	12,878	13,512
Finance charges allocated to future periods	(7,968)	(8,683)
Net lease liabilities	**14,398**	**15,549**
Of which payable		
- not later than one year;	1,343	1,561
- later than one year and not later than five years;	4,492	5,206
- later than five years.	8,563	8,782

Note 21.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	**277**	**1,370**	**94**	**4,955**	**6,696**
Change in the discount rate	2	25	-	-	**27**
Arising during the year *	1	6	50	286	**343**
Utilised during the year	(75)	(88)	(17)	(460)	**(640)**
Reversed unused	(7)	(147)	(65)	(252)	**(471)**
Unwinding of discount	(2)	(11)	-	-	**(13)**
At 31 March 2022	**196**	**1,155**	**62**	**4,529**	**5,942**
Expected timing of cash flows:					
- not later than one year;	62	88	62	1,011	**1,223**
- later than one year and not later than five years	116	364	-	1,453	**1,933**
- later than five yeas	18	703	-	2,065	**2,786**
Total	**196**	**1,155**	**62**	**4,529**	**5,942**

* Within the "other" category is an amount of £271k relating to clinicians' pension tax. Trusts are required to apply paragraph 54 of IAS 37 and offset income to be reimbursed against this expenditure by the Department of Health and Social Care. Therefore, no costs are reflected in operating expenditure for this provision increase.

Pensions
Relates to sums payable to former employees having retired prematurely from work. The outstanding liability is based upon current and expected benefits advised by the NHS Pensions Agency and the computed life expectancies of pension recipients

Legal claims
Based upon professional assessments which are uncertain to the extent that they are an estimate of the likely outcome of individual cases. Due dates of settlement of claims are based upon estimates supplied by NHS Resolution and/or legal advisers.

Other
The Trust has recognised a provision, broadly equal to the tax charge, for clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in the tax year 2019/20, and only in that year, face a tax charge in respect of the growth of their NHS pension benefits. This is offset by a commitment from NHS England and the Government to fund the payments to clinicians as and when they arise. The provision and offsetting asset will initially increase year on year in line with the pension scheme growth, and be released as commitments are met.

A further provision is recognised for an onerous contract relating to the biofuel energy centre. This recognises the future interest charges due over the life of the financing arrangement but where no economic benefit is being received from the centre.

Note 21.2 Clinical negligence liabilities
At 31 March 2022, £657,758k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East Suffolk and North Essex NHS Foundation Trust (31 March 2021: £227,223k).

Note 22 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	27,983	4,706
Intangible assets	41	58
Total	**28,024**	**4,764**

Note 23 On-SoFP PFI arrangements

Note 23.1 On-SoFP PFI obligations
The Trust has two PFI schemes recognised on SoFP. The first is the Garrett Anderson Centre at Ipswich Hospital and the figures reported below relate solely to this scheme.

The Trust's other PFI arrangement for staff accommodation is accounted for as a service concession, in accordance with IFRIC 12. The service operator receives all of its income from individual users rather than in the form of unitary payments from the Trust. As such there is no service charge but the asset is recognised under non-current assets on the Statement of Financial Position with a corresponding deferred income liability (see note 18).

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2022 £000	31 March 2021 £000
Gross PFI liabilities	**22,372**	**24,195**
Of which liabilities are due:		
- not later than one year;	1,823	1,823
- later than one year and not later than five years;	5,843	6,326
- later than five years.	14,706	16,046
Finance charges allocated to future periods	(5,134)	(5,794)
Net PFI obligation	**17,238**	**18,401**
- not later than one year;	1,205	1,163
- later than one year and not later than five years;	3,767	4,103
- later than five years.	12,266	13,135

Note 23.2 Total on-SoFP PFI commitments
Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI arrangements	**64,685**	**64,440**
Of which payments are due:		
- not later than one year;	4,620	4,296
- later than one year and not later than five years;	18,482	17,184
- later than five years.	41,583	42,960

Note 23.3 Analysis of amounts payable to PFI operator
This note provides an analysis of the unitary payments made to the PFI operator:

	2021/22 £000	2020/21 £000
Unitary payment payable to PFI operator	**4,267**	**4,245**
Consisting of:		
- Interest charge	660	700
- Repayment of balance sheet obligation	1,163	1,123
- Service element and other charges to operating expenditure	846	864
- Contingent rent	1,121	1,086
- Addition to lifecycle prepayment	477	472
Other amounts paid to operator due to a commitment under the PFI contract but not part of the unitary payment	10	72
Total amount paid to PFI operator	**4,277**	**4,317**

Note 24 Financial instruments

Note 24.1 Financial risk management

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

Financial risk management
The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is routinely reported and is subject to review by the Trust's internal auditors

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. As such, the Trust does not undertake transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. The Trust has no overseas operations.

Credit risk
As the majority of the Trust's revenue comes from contracts with other NHS bodies, the majority of the Trust's customers are clinical commissioning groups, NHS providers and NHS England. As such, credit risk in this area is considered to be linked to disputes over activity rather than the customers' ability to pay. Other potential customers may be subject to an appropriate credit check or restricted credit limit before activity is undertaken (where clinical priorities allow). Where debtors exceed any agreed credit terms appropriate provision is made against that class of debt. Therefore, the Trust considers that it has a low exposure to credit risk.

Liquidity risk
The NHS Trust's net operating costs are incurred under annual service contracts with local clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk
The Trust borrows from Government for capital expenditure subject to affordability. The borrowings are for 1-25 years and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Alternatively, the Trust can borrow on a commercial basis and would only take such loans on a fixed rate basis. The Trust therefore has low exposure to interest rate fluctuations.

Note 24.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	19,730	19,730
Cash and cash equivalents	99,655	99,655
Total at 31 March 2022	**119,385**	**119,385**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	15,457	15,457
Cash and cash equivalents	106,381	106,381
Total at 31 March 2021	**121,838**	**121,838**

Note 24.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	14,948	14,948
Obligations under finance leases	14,398	14,398
Obligations under PFI and other service concession contracts	17,238	17,238
Other borrowings	455	455
Trade and other payables excluding non-financial liabilities	122,139	122,139
Total at 31 March 2022	**169,178**	**169,178**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	18,289	18,289
Obligations under finance leases	15,549	15,549
Obligations under PFI and other service concession contracts	18,401	18,401
Other borrowings	452	452
Trade and other payables excluding non-financial liabilities	105,720	105,720
Total at 31 March 2021	**158,411**	**158,411**

Note 24.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022 £000	31 March 2021 £000
In one year or less	129,372	111,330
In more than one year but not more than five years	18,174	23,662
In more than five years	34,734	37,896
Total	**182,280**	**172,888**

Note 24.5 Fair values of financial assets and liabilities

As at 31 March 2022 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

Note 25 Losses and special payments

	2021/22 Total number of cases Number	2021/22 Total value of cases £000	2020/21 Total number of cases Number	2020/21 Total value of cases £000
Losses				
Cash losses	33	28	62	98
Bad debts and claims abandoned *	31	974	116	816
Stores losses and damage to property	2	101	2	110
Total losses	**66**	**1,103**	**180**	**1,024**
Special payments				
Ex-gratia payments **	61	644	58	57
Total special payments	**61**	**644**	**58**	**57**
Total losses and special payments	**127**	**1,747**	**238**	**1,081**

* In 2021/22 the Trust suffered a loss of £759k from irrecoverable debts resulting from the liquidation of Concordia Community Outpatients Limited.

** Guidance issued for 2020/21 year end asked employers to accrue the cost of the nationally agreed corrective payments and associated income based on the nationally generated estimates.

These payments are considered special payments for which HMT approval was sought nationally by NHS England on local employers' behalf. As the losses and special payments note is prepared on an accruals basis (excluding provisions), these amounts should have been disclosed in 2020/21 accounts. However, the retrospective payments to the affected employees were made during 2021/22 and have been reported in that year. The prior year figure for ex-gratia payments has therefore not been restated in respect of these claims.

Note 26 Related parties

NHS foundation trusts are deemed to be under the control of the Secretary of State, in common with other NHS trusts. The Department of Health and Social Care is considered to be the Trust's parent organisation and other NHS bodies are therefore classed as related parties. During the financial period, the Trust had a number of material transactions with NHS bodies, all of which were at arm's length. None of the Trust's balances with related parties are held under security or guarantee. In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies during the year.

Related Party Transactions (over £5m)	2021/22 Income £000	2021/22 Expenditure £000	2021/22 Receivables £000	2021/22 Payables £000	2020/21 Income £000	2020/21 Expenditure £000	2020/21 Receivables £000	2020/21 Payables £000
West Suffolk NHS Foundation Trust	3,778	12,991	115	945	4,777	11,461	1,624	938
NHS Ipswich & East Suffolk CCG	298,781	-	-	2,372	274,088	(895)	-	1,868
NHS Mid Essex CCG	24,981	24	4	-	24,500	24	64	24
NHS North East Essex CCG	422,106	-	1,636	907	300,828	407	-	1,447
NHS West Suffolk CCG	14,459	39	54	785	11,006	178	1	787
NHS England	119,885	134	3,516	579	160,063	40	3,553	3,915
Public Health England (PHE)	-	-	-	-	441	3,959	5	248
Health Education England	22,689	34	794	447	21,855	13	96	-
NHS Resolution	-	26,140	-	89	-	25,214	-	-
HM Revenue & Customs	-	40,678	-	10,943	-	35,933	-	9,402
NHS Pension Scheme	-	66,600	-	6,600	-	60,898	26	6,670
NHS Professionals	-	46,015	-	4,836	3	38,175	3	3,331
Suffolk County Council	393	6,126	55	20	405	2,312	24	263

During the period, none of the members of the Board of Directors, Board of Governors or members of the key management staff, or parties related to them, have undertaken any material transactions with the Trust.

By virtue of the Trust's director of estates and facilities being a director and president of the Institute of Healthcare Engineering and Estates Management (IHEEM), the Trust considers this organisation to be a related party. The Trust expended £2.7k on course fees with IHEEM in 2021/22 (£7.0k in 2020/21).

For 2021/22 the Department of Health and Social Care has identified that certain ministers, senior officials and non-executive directors have transacted with entities which are therefore also deemed to be related parties of entities within the Departmental Group. Of these entities, the Trust has reported the following transactions:

- The Leeds Teaching Hospitals NHS Trust – expenditure of £10.1k in 2021/22 (£14.3k 2020/21).
- Vyaire Holding Company – expenditure of £143.7k in 2021/22 with Vyaire UK 236 Limited (£19.6k 2020/21).
- Vyaire Holding Company – expenditure of £11.4k in 2021/22 with Vyaire Medical Products Limited (£13.6k 2020/21).
- Medicines and Healthcare Products Regulatory Agency – expenditure of £6.6k in 2021/22 (£5.4k 2020/21).

The Trust is the corporate trustee of the East Suffolk and North Essex NHS Foundation Trust Charitable Fund. The Trust receives grants to purchase items to benefit patient and staff welfare which are above and beyond those that would be considered as part of the normal operating activities of the Trust. The charity had no material transactions with the Trust.

Note 27 Transfers by absorption

On 1 November 2020 the microbiology service was transferred back to the Trust from Public Health England. This transfer was effected under absorption accounting as directed by the GAM as a machinery of government change.

In line with the requirements of the DHGAM 2020/21, the assets associated with the service were transferred at book value and were not adjusted to fair value prior to recognition.

In 2021/22, a residual gain on transfer by absorption of £22k is recognised in the SOCI which represents an adjustment to the book value of the net assets transferred on the date of acquisition, which was notified to the Trust subsequent to the closure of the 2020/21 accounts.

The value of assets and liabilities acquired is below:

	2021/22	2020/21
Assets	£000	£000
Property, plant and equipment	22	318
Total net assets transferred	**22**	**318**

Note 28 Events after the reporting date

The financial statements were authorised for issue by the Trust Board on 7 July 2022. There were no events after the reporting date which are required to be disclosed in the financial statements in the current year.