NHS
Southend University Hospital
NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2018/19

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Southend University Hospital NHS Foundation Trust

Annual Report and Accounts 2018 – 2019

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

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1. Annual Report Introduction

1.1 Foreword by Chief Executive Clare Panniker and Chairman Alan Tobias OBE

As with many acute Trusts across the country and our partners in mid and south Essex we have continued to respond to pressures on our services throughout the year, including a sustained demand for our urgent and emergency care services. Additionally we continue work to address the financial challenges across our local health and care system.

However, we are pleased that we continue to receive positive feedback from our patients about the care and treatment we are providing, despite the challenges we have faced.

To assist us in effectively managing the flow of patients through our hospital, we successfully undertook a programme of work to implement the TeleTracking IT system across the mid and south Essex hospitals group. We are optimistic that the detailed overview the system gives us of where patients are both geographically and along their clinical journey towards discharge from hospital, will enable us to improve our patients' experience in hospital and respond more effectively as a group to the demands on our services.

While we are continuing to work collaboratively with colleagues across health and social care locally the challenge of balancing demand for urgent and emergency care with our commitment to meeting standards for treating patients remains, particular for those patients requiring elective surgery and patients with cancer. This only reinforces the need to continue work already underway to transform the way we provide services as a system.

To support this, we have started to bring together Corporate Support Service teams from across our hospital group into single teams, with the majority located centrally at our Britannia Park buildings. Bringing our Corporate Support Services together as single teams is the most effective way to support our Trusts through the planned clinical service changes, while also realising the cost improvements associated with more efficient shared processes and teams.

On behalf of the Board, we would like to extend our gratitude to all of our staff who have contributed to maintaining our patients' safety and providing high quality care under the exceptional pressures on our services and through the considerable transformational change we have commenced this year.

It has become increasingly clear in recent years with most NHS commissioners and providers in recurrent financial deficit, as well as other systemic problems such as shortages in the clinical workforce, that the NHS requires fundamental changes if it is to be clinically and financially sustainable. We have seen the need for this at Southend with the ongoing increase in demand for care at levels which, ten years ago, were only experienced in winter.

It has been estimated that without transformational change, the current financial deficits in Mid and South Essex are likely to rise significantly in the coming years. If this happens, then the local NHS would be unable to meet year-on-year growth in demand for our services. These increases in demand, coupled with the chronic staff shortages and the financial deficits are amongst the key risks to the Trust achieving its short and long term objectives.

The Mid and South Essex Sustainability and Transformation Partnership (STP), formerly known as the Success Regime, has the overarching aim of restoring the health and social care system to financial balance within the next five years by delivering the best joined up, evidence-based and personalised care for patients. It incorporates six priority areas in which to accelerate change to sustain local services and improve care.

These priorities include increasing collaboration and service redesign across the three acute trusts (Southend University Hospital NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust and Mid Essex Hospital Services NHS Trust), utilising a flexible workforce that can work across organisational and geographic boundaries (minimising the impact of staff shortages); accelerating plans for change in urgent and emergency care such as doing more to help people avoid health problems and to get help at the right time, developing centres of excellence; developing joined-up community services around defined localities or hubs; and simplifying commissioning to reduce the associated transaction costs.

Following an extensive period of engagement with clinical leaders, staff, partner organisations, regulators and other internal and external stakeholders over a near two year period, a pre-consultation business case (PCBC) for the transformation of clinical services across the Mid and South Essex STP was developed. This was formally assessed by NHS England as being suitably robust for a public consultation and approved by the Joint Committee of the five CCGs in the STP area. The public consultation took place from 30 November 2017 to 23 March 2018. The outcome was systematically analysed and proposals for service change were approved by the Joint Committee in July 2018. Patients will start to see changes being implemented towards the end of the year 2019.

In January 2018, the Boards of the three acute trusts agreed to progress a formal merger, subject to regulatory approval. Whilst this decision is separate from the consultation and decisions around clinical transformation, the Trust Boards are clear that a merger, leading to a single acute trust in Mid and South Essex, will bring specific benefits to patients and to staff. Our target timescale for establishing a new merged organisation is 1 April 2020. Over the forthcoming year, there will be extensive engagement and involvement with our staff and our Governors to design an organisation which will be in the best place to deliver the benefits arising from clinical change.

The collaborative working that the three trusts have been undertaking since early 2016 has taken us to a point where we can deliver more joined-up care which crosses organisational and geographic boundaries. We would like to commend the professionalism and commitment to partnership working in the interests of patients which continues to be shown by colleagues here at Southend and those at Mid Essex and Basildon Hospitals.

This year has seen ongoing development of the Executive Team which was established in February 2017 to provide executive leadership to the three acute trusts that form the mid and south Essex hospitals group. Further details on the joint executives can be found in section 3.1.3.

To provide additional capacity and to address a skills gap in the team, we created the position of Chief Commercial Officer within the team and welcomed Jonathan Dunk to this new role in May 2018. Jonathan's portfolio includes the future organisational form programme and the transformation of corporate support services.

Our Chief Human Resources Director, Mary Foulkes, left the Executive Team in November 2018 after several years' service, first as Southend's HR Director and then in her subsequent role as a joint executive. Following Mary's departure we took the opportunity to bring together the HR and Organisational Development functions under the leadership of a new executive post – Chief People and OD Director. We were delighted to appoint Danny Hariram to this role in November 2018. Our hospital group is benefitting from Danny's experience working at executive level in the Essex acute sector since 2015.

We welcomed a substantive Chief Estates and Facilities Officer, Eamon Malone, in early December 2018, to provide leadership to this crucial area of our current business needs and future strategy. We thank Paul Kingsmore and John Henry for providing excellent interim leadership to this agenda over the preceding year.

We would like to thank all our executive and non-executive Board members, as well our site leadership team led by Managing Director Yvonne Blücher, for their continuing commitment, support and flexibility during this year of significant operational pressure and of progress towards transformational change.

As we go into 2019/20 we welcome the opportunities ahead to build ever-closer working relationships with our colleagues at Basildon and Mid Essex and progress in earnest towards a new organisational form. As part of the Mid and South Essex Sustainability and Transformation Partnership, build a future for healthcare which is clinically and financially sustainable for year ahead.

Last but certainly not least, as always, we take this opportunity to recognise the passion, commitment and support of our staff and volunteers without whom we could not provide the care with compassion that sits at the centre of our values.

We hope you enjoy reading our annual report and should you wish to get involved with any aspect of Trust life, please contact our communications team at communications@southend.nhs.uk

Clare Panniker
Chief Executive
Date: 29 May 2019

Alan Tobias OBE
Chairman
Date: 29 May 2019

2. Performance Report

2.1 Overview of Performance

The purpose of this overview section is to provide a short summary containing sufficient information for readers of the Annual Report and Accounts to understand the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during 2018/19.

2.1.1 Statement from Chief Executive on 2018/19 performance

Throughout 2018/19, performance against the three key national standards, Accident and Emergency (A&E) 4-hour target, cancer 62-day target and 18-week referral to treatment (RTT) target remained exceptionally challenging.

Emergency care demand (attendance to our A&E department) increased by 3.56% (from 101,044 to 104,645) compared to last year. Elective care episodes for 2018/19 were 55,365 compared to 56,113 in 2017/18.

Although the year 2018/19 was challenging it delivered some successes supporting the emergency care pathway with a number of innovative and enhanced models of delivery. These include the introduction of RAT (Rapid Assessment and Treatment) providing for a speedier initial assessment of patients delivered through a purpose built facility within the A&E Department and the roll out of Teletracking that has provided greater transparency of patient flow between A&E and inpatient wards as well as providing immediate visibility of available bed capacity across the hospital.

We have continued to operate an extended primary care streaming model in support of A&E delivery and this has helped us to manage the increase in A&E attendances that we have seen in 2018/19.

We continue to offer direct specialist access to GP referred patients through the Day Assessment Unit (DAU) and we have continued to maximise the use of our ambulatory care service.

Significant workforce gaps have once again impacted our overall position, however those gaps are being reduced through recruitment and we continue to have an improving picture in regards to our retention strategies across the Trust.

Whilst dependency and acuity in A&E attendance remained high and overall A&E attendances increased, conversion to admission reduced to 21.96% in 2018/19 compared to 23.2% in the previous year. Collaborative partnership working aimed to get patients home to their families without delay in hospital continued throughout the year providing an increasing focus on those patients with lengths of stay exceeding 7-days and those requiring additional support due to complex care needs.

Increasing patient volumes combined with higher acuity and dependency placed significant pressure on our main medical wards that in turn led to an increase in medical outliers and the opening of additional escalation beds. The hospital enacted the escalation processes introduced in the previous year enabling the safer distribution of patients throughout the site and therefore supported patient safety at times of highest demand.

62 Day cancer performance was below trajectory and plan in 2018/19. The Trust focused on reducing the patients waiting over 104 days. At the end of the year only 2 patients were waiting more than 104 days for avoidable reasons (i.e. that the trust could have taken action to prevent the delay). The Trust's improvement plan focussed on pathology, urology and radiology. In line with the recovery plan pathology turnaround time for patients on a cancer pathway has seen significant improvement and is now in line with the target time. This has allowed patients diagnosis appointment to be moved to earlier in the pathway, and this will show impact in future months. The urology position has improved although it will need to improve further to allow us to deliver the standards consistently.

Radiology has delivered the improvements and consistently meets the turnaround times. The focus of recovery has now moved to reducing the number of patients waiting more than 62 days. We had set a trajectory to reduce the number to 46 by 31 March 2019, and achieved 47 (from a starting position of 73). The aim for 2019/20 is to reduce the number of patient waiting over 62 days to 37; this would then mean we could consistently meet the cancer treatment target. Areas of concern are gynaecology and access to endoscopy.

RTT performance was below trajectory and plan for the year. The largest growth in PTL (Patient Tracking List) size are orthopaedics (924) mainly driven by increased referrals levels , urology (908) due to the switch of resources to manage the significant growth in referrals and treatments for cancer and gastroenterology (581) which is also impacting on capacity for endoscopy. The most significant reduction in PTL size is for ophthalmology (992) which is in line with the speciality recovery plan. Plans for increasing the activity for orthopaedics and urology are being discussed with the CCG, for the 2019/20 plan and a system wide plan is being agreed for gastroenterology including endoscopy.

2.1.2 Introduction to the Trust

The hospital was officially opened in 1932 and was authorised as a Foundation Trust in 2006. Foundation status gives us more control over how we spend our money and plan our services. We remain firmly part of the NHS and are subject to NHS standards, performance ratings and inspections. The Trust is regulated and licensed by NHS Improvement, the independent regulator of foundation trusts and is registered with the Care Quality Commission (CQC) for the services we provide.

Based on mid-2017 population estimates, Southend-on-Sea, Rochford and Castle Point have a combined population of 355,200, which represents 24.1% of the population of Essex. The Trust serves this population for general acute services and is the largest employer in the Southend area, with a workforce of over 4,500 staff.

Excluding the London boroughs, Southend-on-Sea is the 10th most densely populated area in the UK. In common with many other areas, population projections demonstrate that there is likely to be a significant growth in the number of older people in the years to come.

The population of Essex is projected to grow from 1.47m in 2018 to 1.59m in 2028 whilst the combined population of Southend-on-Sea, Rochford and Castle Point is projected to grow from 360,000 in 2018 to 384,000 in 2028.

Southend-on-Sea, Castle Point and Rochford have a higher combined percentage population over 65 years of age than the UK average, 22.3% compared to the UK average of 18%. This higher than average population cohort continues to expand on the basis of the population projections, with a combined area percentage of 25% projected in 2026 and 28.6% projected in 2036.

The most recent data show 18.5% of Southend's population, 19% of Castle Point and 17% of Rochford reported a long-term health problem or disability that limits their day-to-day activities, in comparison with a regional value of 16.7% and a rate of 17.6% in England.

From the factors described above it is clear that our local population have complex health needs and will require the support of health services more frequently. These factors combine to present a series of challenges to the Trust, in common with health providers across mid and south Essex, and we are facing these challenges in a collaborative way across the health care system as part of the mid and south Essex Sustainability and Transformation Plan (STP).

NHS Southend Clinical Commissioning Group and NHS Castle Point Clinical Commissioning Group were the Trust's main commissioners during 2018/19, with cancer services and renal dialysis commissioned by specialist commissioners, hosted by NHS England.

The Trust has a Council of Governors with local, elected public and staff governors and appointed stakeholder governors. The Council of Governors is responsible for holding the Non-Executive Directors to account for the performance of the Board and for the appointment of the Chairman and Non-Executive Directors. The Trust has a duty to consult and involve the governors in the strategic plans of the organisation. The governors act as a communications channel for our foundation trust members, ensuring their views are represented when important decisions are taken about services and the future direction of the organisation.

Southend University Hospital NHS Foundation Trust (SUHFT) provides a wide range of acute services (see Appendix 1) from the main Prittlewell Chase site and at outlying satellite clinics across the local area. It also provides specialist services to a wider population in south east Essex including cancer, stroke, aneurysm, breast screening and ophthalmology.

2.1.3 Key issues and risks

In the year 2015, the Trust published its five-year plan and outlined its strategic objectives as follows:

- Excellent patient outcomes.
- Excellent patient experience.
- Engaged and valued staff.
- Financial and operational sustainability.

The Board reviewed its Board Assurance Framework (BAF) in March 2019 and agreed the following as key risks that could affect the Trust in delivering the above objectives:

- Failure to provide adequate patient safety, quality of care and patient experience due to capacity, demand and external agency stakeholder engagement.
- Failure to meet constitutional and national performance targets.
- Trust not being financially sustainable.
- Inability to recruit and retain staff.
- Current and future estates, infrastructure and equipment does not comply with national specifications, meet service needs and/or service user needs.
- Lack of robust IT infrastructures, business continuity plans and digital defences against cyber security.
- Failing to meet CQC Health & Social Care regulations.

2.1.4 Going concern disclosure

The Board has considered the Trust's current financial position, future financial plans and associated risks and after making appropriate enquiries, the Directors have a reasonable expectation that the Trust has adequate arrangements to continue in operational existence for the foreseeable future.

Although the Trust recorded a deficit in the year, it delivered its control total position and is projecting a breakeven position (after non-recurring central funding) in the year ahead. The Trust's performance and future planning is regularly discussed in detail with NHS Improvement.

A revenue support loan to support the Trust's deficit has been utilised during 2018/19 and we fully anticipate the Department of Health (DoH) will continue to provide access to sufficient operating cash for the foreseeable future.

We have a dedicated Transformation/PMO team working together with the Trust to implement and deliver the efficiency savings identified. Plans for the cost improvement programme (CIP) for 2019/20 are in various stages of development including those already delivering and will ensure that the Trust is well positioned to achieve its control total for next year and provide a good foundation for the following year.

The Trust is also fully involved in the regional Sustainability and Transformation Plan and the Group Transformation plan, both designed to bring the local health system back into financial balance.

For these reasons, the Board continue to adopt the going concern basis in preparing the financial statements.

2.2 Performance analysis

2.2.1 Performance framework

During 2018/19, the monthly performance framework which was introduced in 2015/16 continued to be fully utilised in the Trust. A standardised reporting template was completed monthly by each directorate. This report demonstrated compliance against the CQC domains (safe, effective, caring, responsive and well led) and against financial targets.

The performance framework sets out a clear reporting structure whereby each month the completed performance report is formally reviewed by each directorate's own board. The Site Leadership Team (SLT) receives the performance reports on a monthly basis and reviews these with the clinical director, associate director and head nurse of each directorate. This process has proved effective and enables the SLT to challenge the directorates on their performance over a wide range of measures.

The Integrated Performance Board Report provides an overview and amalgamation of the performance reviews and has been reviewed by the Trust Board on a quarterly basis and by the Non-Executive Directors at Board Development Days on a bi-monthly basis until December 2018 and by the Non-Executive Directors at Site Governance forums on a monthly basis as from January 2019.

Table 1 shows the Trust's key performance indicators.

There are approximately 60 different measures within the performance framework report, however, there are 6 key measures that the Government requires trusts to focus on. These are:

- 18 weeks incomplete referral to treatment time (RTT)
- Cancer targets
- A&E 4-hour target
- MRSA bacteraemia
- C. diff
- Diagnostic 6-week target

Throughout 2018/19, the Trust has not consistently achieved targets or has failed for each quarter, as shown in Table 1.

Table 1: Trust performance 2018 – 2019 (Financial Year)

Measure/Indicator	Target/ Threshold	Annual Compliance	Q1	Q2	Q3	Q4
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	86.67%	87.57%	88.48%	86.51%	84.36%
Total time in A&E under 4 hours	95%	87.05%	93.23%	90.70%	83.41%	80.83%
Cancer 62-day waits for first treatment (from urgent GP referral)	85%	66.8%	72.3%	66.8%	62.6%	66.0%
Cancer 62-day waits for first treatment (from NHS Cancer Screening Service referral)	90%	87.5%	90.0%	90.9%	83.3%	84.5%
Cancer 31-day wait for second or subsequent treatment – surgery	94%	75.5%	78.7%	82.2%	68.4%	74.1%
Cancer 31 day wait for second or subsequent treatment – drug treatments	98%	97.6%	99.4%	97.9%	98.7%	95.2%
Cancer 31 day wait for second or subsequent treatment – radiotherapy	94%	97.1%	96.7%	96.8%	98.1%	96.6%
Cancer 31 day wait from diagnosis to first treatment	96%	92.7%	94.5%	92.5%	93.3%	89.9%
Cancer 2 week (all cancers)	93%	89.8%	90.7%	88.5%	89.8%	90.3%
Cancer 2 week (breast symptoms)	93%	63.5%	79.4%	61.9%	38.5%	68.0%
C-diff due to lapses in care	30*	26	9	6	5	6
Incidents of MRSA bacteraemia	0*	3	0	1	1	1
Diagnostic 6 weeks	99%	98.40%	98.68%	99.28%	99.18%	96.78%

*full year threshold

In conjunction with the local CCGs and agreed by the Trust's regulators, NHS Improvement and NHS England, a series of operational recovery plans and a recruitment strategy have been developed and implemented throughout the year.

The Trust has worked closely with neighbouring trusts to develop the group cancer recovery plan and has worked to agree consistent approaches to A&E GP streaming, full capacity protocols and internal escalation processes.

The CQC requirement to comply with the national safer staffing number guidance imposed in January 2016 continued to impact the number of available beds throughout 2018/19 although this has been somewhat mitigated by the Trust full adoption of our Full Capacity Protocol. This coupled with the increased level of A&E attendances and a national directive to cease the majority of the elective programme during the three months of winter has resulted in delays in treating elective routine patients. The net result of these pressures has impacted the Trust's ability to achieve some of the key national targets as shown in the table 1adjacent.

More details on the Trust's performance are available in the Quality Report in Section 4.

2.2.2 Financial Performance

The Trust was issued with an Income & Expenditure (I&E) Control Total of £10.5m deficit which included Sustainability & Transformation Funding (STF) of £10.8m. Receipt of the latter was conditional on achieving the pre-STF Control Total and the A&E 4-hour target. This is summarised as follows:

Pre-STF Control Total	-£21.3m deficit
Less: STF	£10.8m
Post STF Control Total	-£10.5m deficit

The plan for 2018/19 reflected a number of financial pressures including an efficiency assumption within the national tariff of 2.0%, and some significant items of unfunded expenditure inflation (e.g. increased contributions in respect of the Clinical Negligence Scheme for Trusts). It was clear that to achieve financial stability and to develop the capacity to invest in services, the Trust would need to make continuous improvements in both its basic service delivery and in the way it used its assets and resources.

A number of developments were funded by the Trust within its 2018/19 plan, including the implementation of Teletracking, and development of a Hospital at Home service, the increase of the number of medical beds at the Trust as well as the Ambulatory services provided by the Trust. Consequently, to be able to fund these developments and deliver the control total a cost improvement target was set of £12m which was equivalent to 3.8% of income and therefore higher than the underlying tariff efficiency of 2%.

Given that the Trust achieved its 2017/18 Control Total, an STF incentive and bonus of £6.41m was provided by NHSI. This was a cash receipt in 2018/19, but was part of the 2017/18 I&E position. The funding was ear-marked for capital schemes, namely the construction of RAT bays in A&E and the re-development of the Trauma Assessment Centre (TAC).

Table 2 overleaf (which is used for internal management reporting) shows the Trust's actual performance against plan.

Table 2: Trust performance against plan

Description	Year to Date		
	Budget	Actual	Variance
	£m	£m	£m
Income	312.048	316.573	4.525
Pay	(203.949)	(203.880)	0.069
Non Pay	(114.298)	(119.773)	(5.475)
Financing	(15.127)	(14.220)	0.907
Pre PSF Control Total	**(21.326)**	**(21.300)**	**0.026**
PSF Income	10.786	9.654	(1.132)
Surplus / (Deficit) (Control Total)	**(10.540)**	**(11.646)**	**(1.106)**
Impairments / Donated Asset I&E	0.000	(2.490)	(2.490)
PSF Incentive Bonus	0.000	6.668	6.668
Surplus / (Deficit)	**(10.540)**	**(7.468)**	**3.072**

In overall terms, the Trust delivered a net deficit of £7.468m which was £3.072m better than plan. This includes the Provider Sustainability Fund (PSF) bonus awarded to the Trust. The Trust delivered its financial plan excluding the PSF and technical adjustment.

NHSI regards the Pre-PSF Control Total as a more relevant indicator of operational financial performance and on this measure the Trust delivered its control total. As a consequence, NHSI has notified the Trust of a non-recurring PSF incentive bonus for 2018/19 of £6.668m.

Clinical income was based on a fixed value contract from the 5 main CCG Commissioners and a Payment by Results contract from NHS England. The fixed value contract being agreed at a value higher than the original offer at the time the plan was set. This together with Cancer Alliance funding received (offset by additional expenditure) saw income perform at £4.525m above budget.

Pay budgets were under-spent by the end of the year, through additional controls put in place as part of the Trust's focus on ensuring it delivered its plan. This saw Agency spend reduce throughout the year, ending at £14.7m, a decrease of £3.7m against the 2017/18 spend of £18.4m. The Trust, however, did not meet the lower Agency target set by NHSI for the year of £9.8m.

Non-pay budgets were over spent throughout the year with the majority of this related to the high activity levels. Drugs, clinical supplies and pathology tests represented a large amount of the over spend. Outsourcing of Ophthalmology and Endoscopy activity to help maintain waiting list positions and provision of a GP streaming service also contributed to this overspend representing the majority of the balance. These costs were directly associated with the higher than planned activity and income level. As the year progressed, increased pressures were also seen on estates repairs and maintenance budgets which reflected the ageing infrastructure of the hospital and the limited capital programme.

The plan included a cost-improvement requirement of £12m which was a significant increase on the £8.8m target of 2017/18. £11.1m of this target was delivered, however £4.6m was delivered as non-recurrent savings, and this will need to be addressed in 2019/20.

The capital programme was set at £14.6m in the plan but was increased to £18.6m due to the receipt of PSF incentive bonus for 2017/18 which was used to fund the A&E RAT bay development, the redevelopment of the Trauma Assessment Centre, some early fire compartmentalisation work and to increase the contingency within the Estates, IT and Equipment budgets. The programme finished the year £0.1m under-spent.

The Trust's cash position was £16m at 31 March 2019 which was higher than plan. This is due to the fact the plan did not include the assumption of the PSF bonus, and also the fact that not all of this has been spent during the year. The timing around a number of other items also benefitted the cash position with a number of late capital acquisitions towards the end of the financial year which will be settled in 2019/20.

2.2.3 Future years

Strong progress has been made within the hospital group *(Mid-Essex, Southend and Basildon hospitals)* in 2018/19, both in terms of the clinical reconfiguration agenda, and the corporate services reconfiguration. The corporate hub is now agreed as Britannia House in Southend, with work having already commenced on its refurbishment and the first group teams moving in early in 2019/20. The Joint Committee of CCGs presented its case for clinical change as part of a public consultation and in July 2018 concluded the consultation, with the public in support of almost all of the recommendations. Although this is now subject to a secretary of state review, the group is still making good progress in the service reconfiguration modelling to understand the impact on each of the three sites, in preparation for the significant reconfiguration of clinical services across the three hospitals over the next few years. Further work has also been ongoing in respect of the development of the Outline Business Case for the Capital works required to support this clinical reconfiguration, supported by the availability of £118m of STP capital which was announced in the Autumn Budget 2017.

However, while the financial plan reflects this collaboration and the joint working approach, it is important to emphasise that the Trust is still an independent organisation and has a requirement first and foremost to ensure that its financial plan enables it to achieve its own performance targets.

The Trust's plan for 2019/20 is a single year plan agreed with NHSI in 2018/19 and sets an Income & Expenditure *(I&E)* breakeven position which includes STF income of £5.5m and Financial Recovery Fund income of £11.1m. Receipt of this income is contingent on delivery of the control total for 2019/20.

The clinical income plan reflects the uplifts in contracts as agreed with commissioners, funding both the uplift of cost of delivery (2.7% net tariff inflator) and an element of growth.

Expenditure inflation of approximately 3% has been incorporated in addition to cost improvements which have been set at £12.5m (or approximately 4% of total income).

The capital programme is severely constrained by the shortage of cash but has been set at £25.6m. This is higher than in previous years as it presumes £4.2m of the sale proceeds of Fossets Farm will be spent on initial STP capital requirements within the group, and also that the Trust will host the system single patient record for which national funding is being received (£4m). The remaining element predominantly relates to the purchase of MRI equipment carried forward from the 2018/19 plan, and the most urgently required backlog maintenance. However, this value does not fully address the condition of the ageing estate and contains potential significant risk for the Trust which are being managed and mitigated. The additional capital notified in the 2017 Autumn Budget and ear-marked for the clinical reconfiguration is not part of this local capital budget.

The Trust relied on cash support in 2018/19 and will again require further support during 2019/20, however is expected to pay back the 2019/20 element in year as it is planning to deliver an overall breakeven position.

2.2.4 Environmental Matters

Sustainability development plan

We continue to monitor, assess and show compliance and delivery of our Sustainable Development strategy (our carbon emissions plan) using the Good Corporate Citizen assessment tool. This management tool allows us to compare our overall percentage environmental performance or score against national benchmarks under the following sustainability categories:

- Corporate approach
- Travel and transport
- Procurement
- Workforce and community engagement
- Facilities management, buildings, adaptation
- Models of care

Our average score in 2017/18 is five percentage points below the national average (45% vs. 50%) and a breakdown of the individual percentages indicates where further developmental work is required, e.g. procurement and models of care, to help us improve our overall score.

ISO 14001 standard

Estates and Facilities Directorate also gained re-certification under the environmental management system ISO 14001:2015. This is an internationally recognised standard to help organisations to improve their environmental performance.

Travel

We use our green travel plan to assess via annual travel surveys the options our patients, visitors and staff use to travel to and from site.

Single occupancy car use by staff in 2017/18 shows a 4.3% increase, bus use a 5.6% increase compared to the year before and reflects the link between higher activity levels, the need to travel and the increased demand for our services.

Travel by car and parking for patients, visitors and staff continue to be a challenge for us including traffic flow in and around the site. To manage the increased number of car users on a short term basis, parking areas shared between patients, visitors and staff are now re-allocated on the following basis:

- Car parking areas A,D, E, F and G are for patients and visitors only and
- Car parking areas B, C and H are for staff only

We robustly manage the staff parking permit or application process by freezing it periodically throughout the year while at the same time promoting initiatives to encourage take up of active and sustainable modes of transport. These include:

- Tax free bike scheme, cycling roadshows, staff benefits days to promote the tax free bike scheme, bus tickets and Dr Bike sessions (where staff can get their bicycle serviced free of charge)
- Interest free credit on 125cc motorbikes and scooters from local Honda dealership
- 50% discounted bus season tickets

We also continue to analyse car parking barrier ticket data to help us better manage traffic and car park flow.

Energy usage and carbon dioxide (CO_2) emissions

The main tools for reducing emissions from the energy used in buildings, processes and infrastructure are the following mandatory government carbon emissions trading schemes.

a) Carbon Reduction Commitment Energy Efficiency Scheme (CRC)

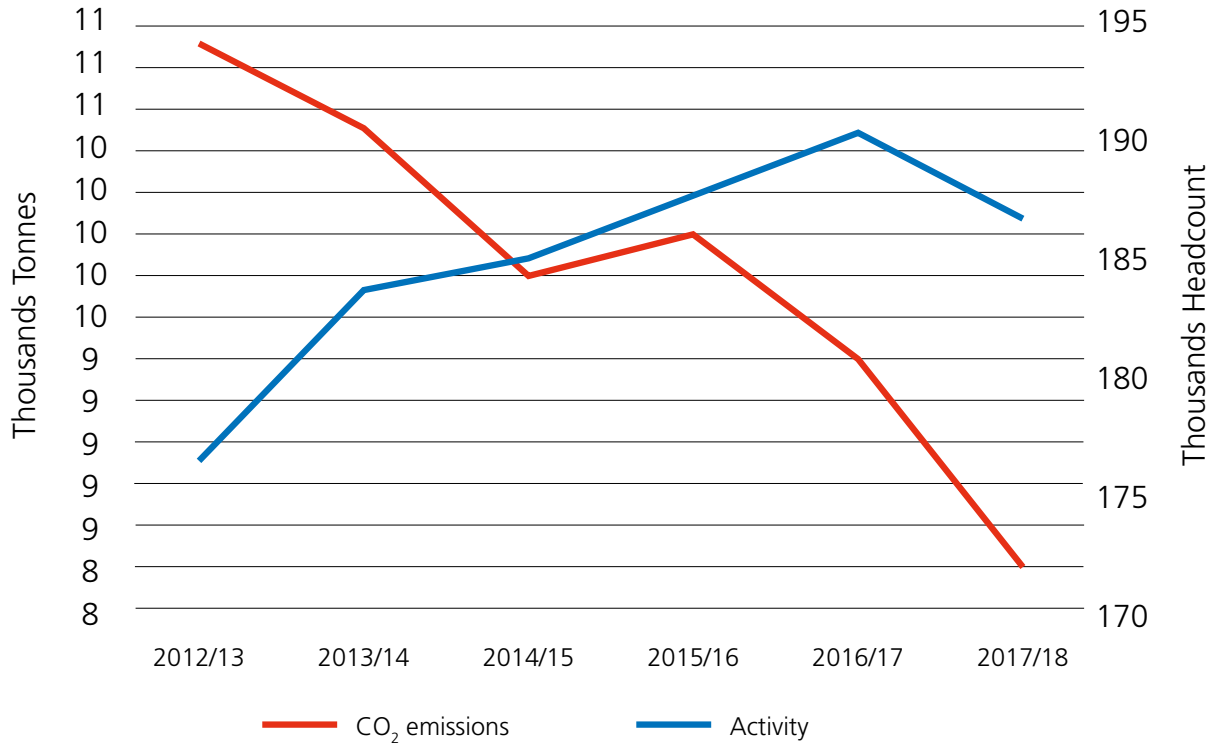
b) European Union Emissions Trading Scheme (EU ETS)

The aim of these schemes is to improve energy efficiency and reduce the amount of CO_2 emitted in the UK by large organisation. The government imposes a price on the CO_2 emitted.

Energy usage in 2017/18 compared to the year before shows a reduction of 6.9% (1.9 million kWh) while the associated CO_2 emissions decreased by 11.1% (1,000 tonnes). This higher percentage reduction reflects the changing generation mix on the electricity grid as well as the installation of CHP (Combined Heat and Power) – see below.

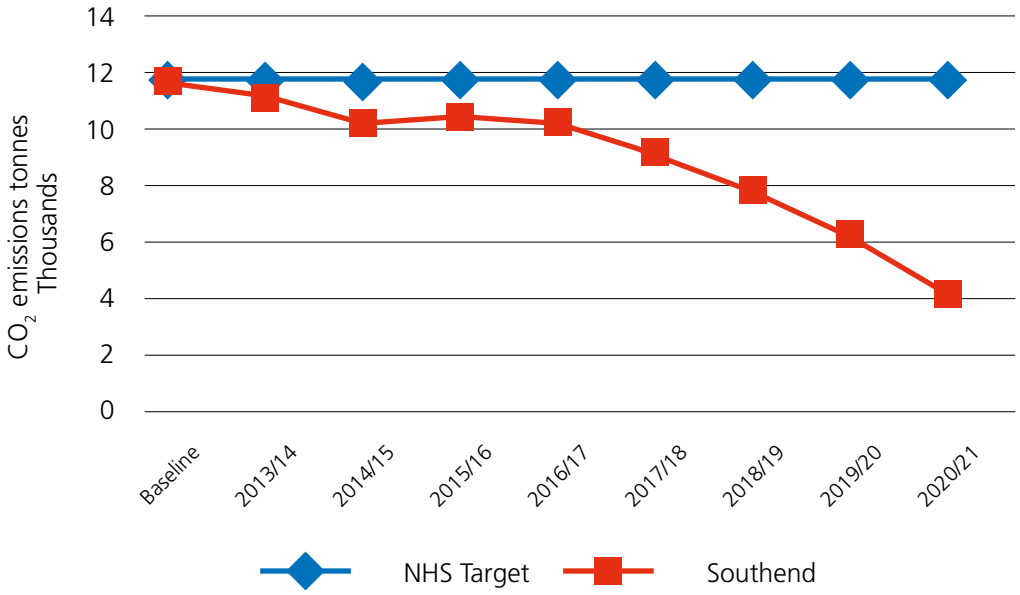
The long term trend for our energy carbon footprint remains favourable. Our CO_2 emissions over the past five years reduced by 22.9% (2,500 tonnes) despite increases in activity of 5.7% (10k) as shown in Figure 1.

Figure 1: CO_2 emissions vs. activity



The ongoing programme to upgrade old and inefficient infrastructure, energy systems such as air handling units and replacing fluorescent lighting with LED lighting, making funds available to tackle our backlog maintenance and CHP will ensure we achieve the national CO_2 emissions targets as indicated in Figure 2.

Figure 2: Energy usage CO_2 emissions



Our CHP only started self-generating electricity in December 2017 and is expected to save some 2,100 tonnes of CO2 emissions annually – by far the biggest contributor to help us meet the NHS target.

We continue to review and explore other energy savings opportunities using, wherever possible, external funding sources to further reduce our CO2 emissions. Integrating best available technologies in new build and major refurbishment works is also a key part of our strategy to ensure the efficient use of resources over the long term.

We also have in place robust business continuity plans to manage the impact of extreme weather conditions, i.e. heatwave policy and air conditioning policy as well as a waste management policy. The aim of these is to help us mitigate and adapt to our changing climate and its impact on healthcare services.

2.2.5 Workforce, Equality, Human Rights and Anti-Bribery

Southend Hospital is committed to fulfilling its obligation as an employer of respect, equality and diversity. We continue to have a full time employee dedicated to ensuring our policies, procedures, training and conduct are compliant with the provisions of the Equality Act 2010. The strategic aims of Equality, Diversity and Inclusion are monitored and progressed through the Equality, Diversity and Inclusion Committee to ensure the Trust meets not only its statutory duties but also best practice. This has been extended to cover Gender Pay Gap in line with the reporting requirements and WDES for 2019. Examples of initiatives undertaken in 2018 include developing 4 successful diversity network groups – BAME, LGBT+, Disability and Faith. These groups have raised their profile within the Trust and have been a voice at many events and celebrations throughout the year. The groups feed into the Equality, Diversity and Inclusion Committee (EDIC) and are part of the overall agenda. Promotion of the equality and diversity agenda continues as part of the Trust welcome day and training for newly qualified and overseas

nurses throughout the year. There is a rolling diversity calendar of events where we hold celebrations and are part of community events throughout the year.

Further to the successful trial in 2017 of contracting an independent Guardian Service, to support the Freedom to Speak up Agenda, this has continued in 2018. Focus has been on embedding the service to foster an open and responsive raising concerns culture where staff feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment. The strategic aims of the Freedom to Speak Up agenda are monitored and progressed through the Freedom to Speak up steering group, which is attended by representatives from across the Trust including the 13 nominated speak up Champions from each directorate, which further promotes the agenda.

From a patient perspective, staff continue to receive training on Adult and Child Safeguarding, Prevent (preventing violent extremism) and Equality and Diversity as a mandatory part of their induction and continued learning.

Our approach to tackling fraud and bribery is explained in the Director's Report (section 3.1) within the Audit Committee Annual Report (section 3.1.8) and under the Staff report (section 3.3) within the Staff Policies and Actions (section 3.3.2).

2.2.6 Social and community issues

The Trust is working with partners across the health system in mid and south Essex, as well as charitable and voluntary providers, as part of the mid and south Essex Sustainability and Transformation Plan (STP) to ensure that the health and care needs of our local population continue to be met as part of the wider strategy for the region.

The Trust works with Southend-on-Sea Borough Council, a unitary authority, and Essex County Council as well as Castle Point Borough Council and Rochford District Council. The Trust's Chief Executive and local site leadership team members attend the Southend People Scrutiny Committee and the Essex Health Overview and Scrutiny committee, as well as the Southend and Essex Health and Wellbeing Boards, ensuring that the Trust is a key part of the development of health and social care services across the Borough and more widely in Essex.

The Trust has close and longstanding links with local voluntary services through the Southend Association of Voluntary Services (SAVS), Castle Point Association of Voluntary Services (CAVS) and Rayleigh, Rochford and District Association of Voluntary Services (RRAVS). We also work in collaboration with Healthwatch both in Southend and Essex, to enable local people to engage with the Trust and get the most from their local health service.

To support the care of our patients both within and outside of the hospital environment, we work with national charities such as the Alzheimer's Society, Stroke Association and Mind to engage and inform our staff about initiatives that can enhance patient safety and care. We also support national awareness-raising days, such as Dying Matters and Stroke Awareness weeks, by working with our specialist staff to provide local context for social media messages, as well as providing health-specific features for the local media.

The Trust's governors and members continue to support the Trust by engaging with local community groups to ensure that the way we provide our services reflects the needs of the community.

2.2.7 Overseas Operations

The Trust does not have any overseas operations.

2.2.8 Any important events since the end of the financial year affecting the Foundation Trust

There was no important event since the end of the financial year affecting the Trust.

Clare Panniker
Chief Executive
Date: 29 May 2019

3. Accountability report

3.1 Directors' report

The directors are responsible for the preparation of the annual report and account and they consider the annual report and accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

The Annual Governance Statement (section 3.7) and the Quality Report (section 4) set out the directors' approach to quality governance. The Board has conducted a review of the effectiveness of its system of internal controls and it is satisfied that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives as stated in the Annual Governance Statement.

3.1.1 The Board of Directors

The Trust is governed by a Board (Southend Hospital Trust Board) which is responsible for ensuring that the statutory objectives are carried out and that the Trust is run in an appropriate, legal way. The Board comprises both full-time executive and part-time non-executive directors; the latter being appointed from the Trust's membership (by the governors) for their broad business experience.

The Board is responsible for the leadership of the Trust by undertaking three key roles:

- Formulating strategy.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that the systems of control are robust and reliable.
- Shaping a positive culture for the board and the organisation.

The Board consults with the governors to produce plans for the future strategic development of the organisation whilst ensuring the required financial and human resources are in place for the Trust to meet its obligations and review management performance.

3.1.2 Collaborative Governance Framework and proposed merger

In December 2016, the Boards of Directors of the three acute trusts in mid and south Essex (Southend University Hospital NHS Foundation Trust, Basildon and Thurrock University Hospital NHS Foundation Trust Hospital and Mid Essex Hospital Services NHS Trust) agreed to enter into a collaborative governance framework with a contractual joint venture to enable them to work more closely together to redesign clinical services, clinical support services and corporate support services as part of the Mid and South Essex Success Regime, whilst remaining three separate and sovereign statutory organisations. The contractual joint venture agreement was signed on 1 January 2017 and came into effect on 1 February 2017.

The Boards agreed to create a "committee in common" governance model, whereby each Board of Directors created a Success Regime Committee (SRC), to which all powers which could, within the confines of law and good governance, be delegated, were delegated. Meetings of these committees take place in common under the operating name of the 'Joint Working Board' (JWB).

The JWB met on a monthly basis between February 2017 and December 2018, conducting the majority of its business in public session.

In Autumn 2018, the Trust Boards decided that the time was right to evolve their governance arrangements as the organisations progressed towards merger. Building on the success of the JWB, the Boards decided that with effect from February 2019, all three Trust Boards would meet in common on a monthly basis. This would ensure that all members of the three Boards had an opportunity to engage fully in key clinical and corporate transformation decisions as we planned together for the new organisation and redesigned services for patients. The Trust Boards would only meet separately in order to approve the annual report and accounts and on an exceptional basis.

The first formal meeting of the Trust Boards in Common under this new arrangement took place in February 2019 with a session in public and a brief closed session.

The Trust Boards also decided that the quality assurance committee and the finance and resources committees of each Trust should meet only in common from January 2019. In view of the fact that workforce recruitment and retention was consistently a significant risk for all three trusts, the Boards decided that a new workforce committee should be created as a committee of each Trust. The workforce committees meet only in common, on a bi-monthly basis.

The Remuneration and Nominations Committees (RemNoms) only meet in common except where there is a particular item which should only be considered by a trust-specific RemNom due to the personal confidentiality of a particular issue.

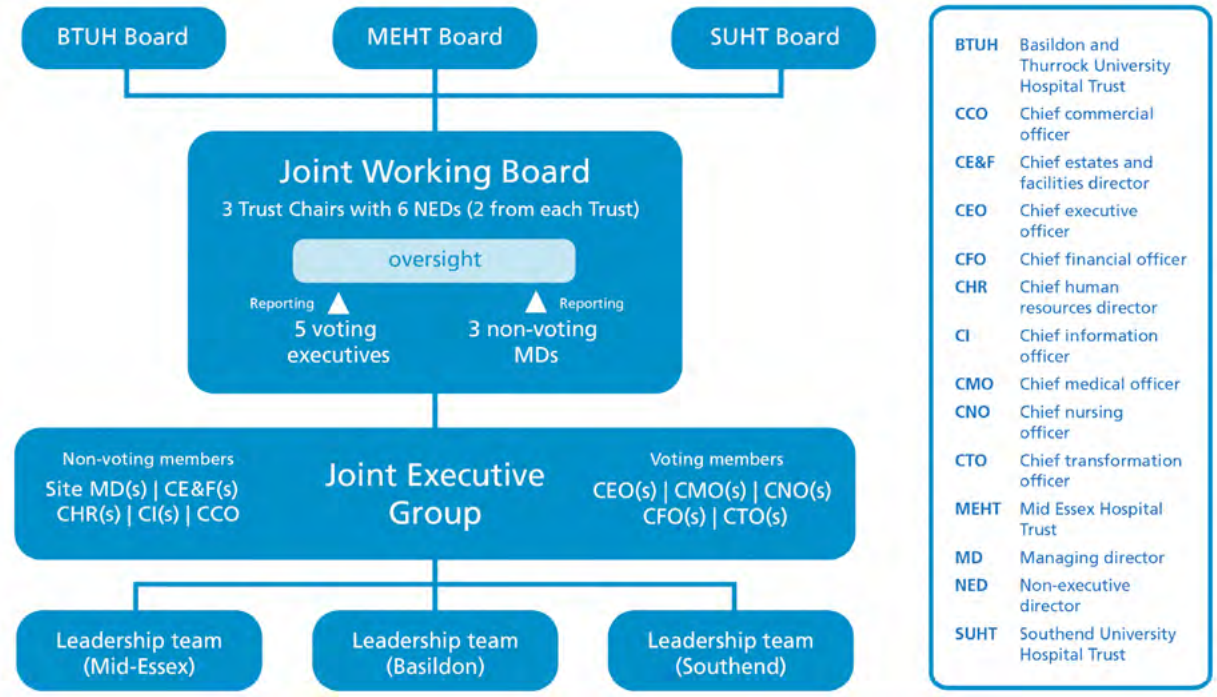
In order to ensure that the non-executive directors have sufficient opportunity to scrutinise performance of their respective trusts, each site now has a Site Governance Forum (SGF). These comprise a monthly meeting of the non-executives and site leadership teams to discuss the integrated performance report relating to that site and any other pertinent issues such as local service developments and emerging risks. The SGFs are able to escalate issues to the committees in common and boards in common on an exception risk-basis. Equally, the committees in common and boards in common may refer particular matters for oversight by the relevant SGF.

The Boards decided that the Trusts' Audit Committees would continue to meet separately, given their pivotal role in ensuring that each organisation has an effective system of governance, internal control and risk management.

At all stages in the development of our collaborative governance arrangements, all parties have been clear that the Board of Directors of each Trust remains legally accountable for the performance of that particular Trust.

The key elements of the collaborative governance framework are shown in Figure 3 below:

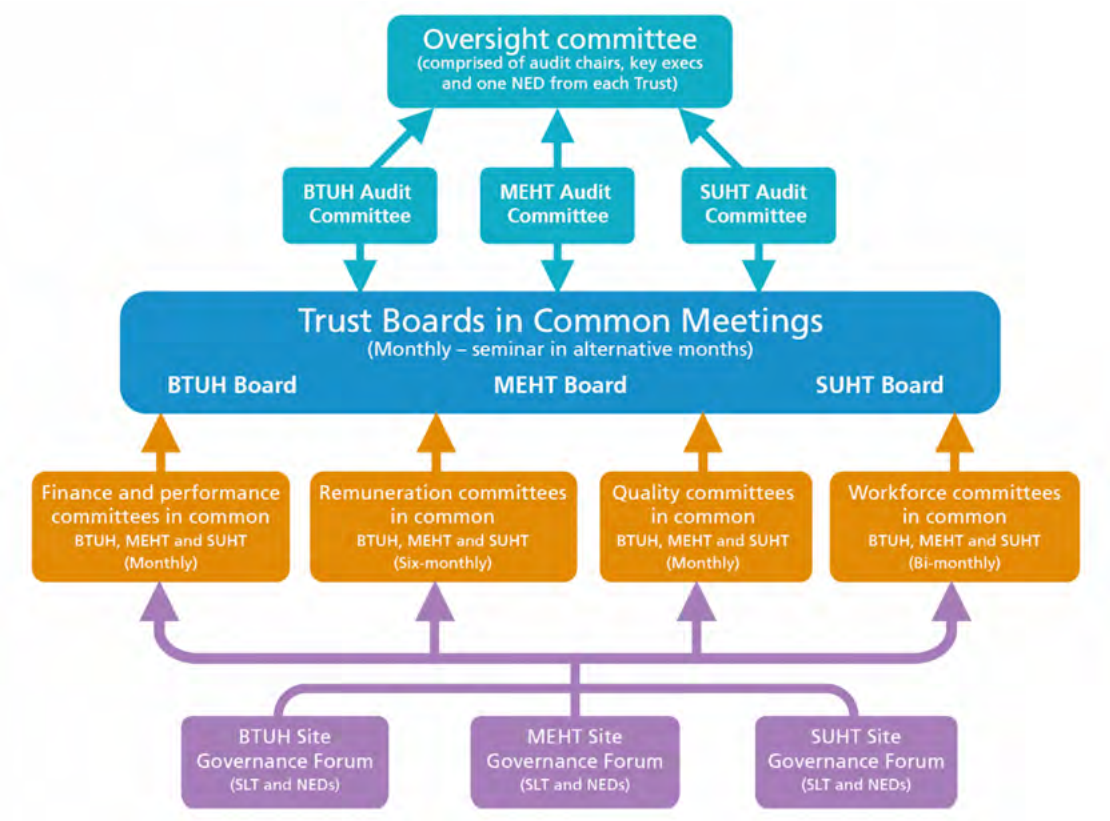
Figure 3: Collaborative governance framework from January 2017 to January 2019



The members of Southend University Hospital Foundation Trust (SUHFT) Success Regime Committee from 1 January 2017 until January 2019 were Alan Tobias OBE (Chairman), Gaby Rydings (Non-Executive Director), Tony Le Masurier (Non-Executive Director) and the Joint Executive Group (JEG) members.

The collaborative governance framework in place from February 2019 onwards is shown in Figure 4 below.

Figure 4: Collaborative governance framework from February 2019



Reviewing the effectiveness of the collaborative governance framework

The collaborative governance arrangements are subject to a programme of scheduled reviews, overseen by a specially convened oversight committee, comprising the chairs of the three audit committees and an additional Non-Executive-Director from each Trust.

In May 2017, the Oversight Committee developed a questionnaire to gather views and feedback from the non-executive directors, joint executives, site leadership teams and Governors across the three trusts to enable the collaborative governance processes to be reviewed, adapted and changed as required to improve effectiveness. The Joint Working Board received a presentation in October 2017 showing the outcome of the review and an action plan was developed to expand upon the broad recommendations which encompassed vision, communication, visibility, accountability, relationships, reporting and workload pressures. A positive progress report on the implementation of learning from this review was produced in October 2018.

The oversight committee plans to conduct another review in early Summer 2019 to ensure that the recent development of the framework is as effective as possible.

3.1.3 Directors of the Trust Board

The Directors of the Trust who served during the year are as shown in Table 3 below.

Table 3: Directors of the Trust

Name	Position	In Year Changes
Alan Tobias OBE	Chairman	Re-appointed in September 2018 until April 2020[1]
David Parkins	Deputy Chairman	Re-appointed in September 2018 until April 2020[1]
Mike Green	Non-Executive Director	Re-appointed in September 2018 until April 2020[1]
Fred Heddell CBE	Non-Executive Director	Re-appointed in September 2018 until April 2020[1]
Tony Le Masurier	Non-Executive Director	Re-appointed in September 2018 until April 2020[1]
Gail Partridge	Non-Executive Director	Re-appointed in September 2018 until April 2020[1]
Gaby Rydings	Non-Executive Director	Re-appointed in September 2018 until April 2020[1]
Tim Young	Non-Executive Director	Re-appointed in September 2018 until April 2020[1]
Clare Panniker	Chief Executive	
Tom Abell	Chief Transformation Officer	
Yvonne Blücher	Managing Director	
Martin Callingham	Chief Information Officer	
Danny Hariram	Chief People & Organisational Development Director	Appointed in November 2018
Eamon Malone	Chief Estates and Facilities Director	Appointed in December 2018
James O'Sullivan	Chief Financial Officer	
Diane Sarkar	Chief Nurse	
Celia Skinner	Chief Medical Officer	
Jonathan Dunk	Chief Commercial Officer	Appointed in May 2018
Directors who served during the year, but are no longer in office:		
Mary Foulkes	Chief Human Resources Director	Left the Trust in November 2018
John Henry	Interim Chief Estates and Facilities Director	September 2018 to December 2018
Paul Kingsmore	Interim Chief Estates and Facilities Director	Left the Trust in August 2018

[1] This is a transitional arrangement which was approved by the Council of Governors in September 2018 due to the proposed merger and will be reviewed in June 2019.

Board Members' Skills and Experience

Non-Executive Directors

Alan Tobias, OBE, Chairman

Alan joined us as chairman in December 2011 from his former position of chairman at West Essex PCT.

He is a qualified solicitor with a strong record of senior management, both in the public and private sector. For 16 years he was the London Boroughs' Chief Executive and latterly chairman of an IT company.

Alan was also Chairman of Essex Probation Service for six years and a board member of Springboard Housing Association as well as a trustee to two charitable trusts. In February 2019, Alan was appointed as chairman of Mid Essex Hospital.

Membership of Committees (April 2018-January 2019): Remuneration and Nomination Committee

Membership of Committees (January 2019 – March 2019): Finance & Performance Committee in common (ex-officio), Quality Committee in common (ex-officio), Workforce committee in common (ex-officio), Remuneration and Nomination Committee in common

David Parkins, FCA, (Deputy Chairman)

David is a Fellow of the Institute of Chartered Accountants (FCA) and has held a number of senior finance roles in the banking sector.

Following a period as finance director with Mortgage Express, part of the Lloyds TSB Group, he was finance director for lending and savings with the Bradford and Bingley group. David has had executive responsibility for audit and experience of corporate governance, joint ventures, treasury and management control systems.

He is treasurer and trustee of Headway Essex, a charity that helps people who have suffered brain injury and their families.

Membership of Committees (April 2018-January 2019): Audit Committee, Finance and Resources Committee (Chair), Remuneration and Nomination Committee; Quality Assurance Committee

Membership of Committees (January 2019 – March 2019): Membership of Committees: Finance & Performance Committee in common (Chair), Remuneration and Nomination Committee in common, Audit Committee

Mike Green, BSc (Econ), FCA, Non-Executive Director

Mike qualified as a chartered accountant with what is now KPMG, and spent 11 years with the audit practice before a 20-year career in the broadcast media industry.

He held senior finance roles at TVS Television Limited and Carlton Communications plc and was involved in the Carlton/Granada merger which formed ITV plc.

Following the merger, Mike moved to ITV and ultimately held the role of deputy group finance director. He now acts as a business consultant and is also currently a Board member of Anchor Hanover which specialises in the provision of housing for older people, an honorary treasurer of the Royal Television Society and a Non-Executive director of the Copyright Hub Foundation Limited.

Mike is also the Trust's Senior Independent Director (SID).

Membership of Committees (April 2018-January 2019): Audit Committee (Chair), Finance and Resources Committee, Remuneration and Nomination Committee, Quality Assurance Committee, Oversight Committee

Membership of Committees (January 2019 – March 2019): Finance & Performance Committee in common, Remuneration and Nomination Committee in common, Audit Committee (Chair), Oversight Committee

Fred Heddell, CBE, Non-Executive Director

A former teacher of children with learning disabilities, Fred was formerly Chief Executive of the national charity Royal Mencap, working alongside the comedy actor and campaigner Lord Brian Rix.

Since then he has acted as treasurer of Inclusion International, working in Africa, Eastern Europe and Central America to help develop inclusive services for people with disabilities. He has also been a non-executive director of the Commission for the Compact, a member of the Strategic Health Authority independent competition panel, a governor of the University of East London and trustee of several voluntary organisations. Fred is a trustee of the Rix Rothenberg Thompson Foundation, a trustee of Teen Talk Harwich and Trustee of signpost.

Membership of Committees (April 2018-January 2019): Audit Committee, Quality Assurance Committee (Chair), Charitable Funds Committee (Chair), Remuneration and Nomination Committee

Membership of Committees (January 2019 – March 2019): Quality Committee in common, Remuneration and Nomination Committee in common, Audit Committee, Charitable Funds Committee (Chair)

Tony Le Masurier, J.P., BA (Hons), Non-Executive Director

Tony joined the Trust board in December 2012. His background is in senior management in the aviation and travel industry, serving as a director and CEO of several large international companies over three and a half decades.

He acted as Interim Chief Officer for the Southend Association of Voluntary Services (SAVS) for two years, and was previously a non-executive director of the local primary care trust for eight years, holding the position of vice chairman for three of those. He is currently a supplemental JP, having retired from sitting in the Family and Adult courts in January 2018, and the chairman of a local care home charity that operates two homes in the borough of Southend-on-Sea.

Membership of Committees (April 2018-January 2019): Remuneration and Nomination Committee (Chair), Audit Committee, Finance and Resources Committee

Membership of Committees: (January 2019 – March 2019): Finance & Performance Committee in common, Remuneration and Nomination Committee in common, Audit Committee

Gail Partridge, Non-Executive Director

Gail Partridge is a registered nurse who trained and worked at Southend Hospital within the surgical directorate from 1981 until 2002 and was appointed as a Non-Executive Director in December 2016.

She has clinical and operational management experience within a variety of health economy settings including acute hospitals, community and mental health services, commissioning support unit as Associate Director of clinical services and Deputy Director of Nursing in NHS England Essex area team. Her extensive experience of working within the NHS has been particularly focused on governance, quality and patient safety, and risk management functions.

Gail currently works as a Director for Quality for Health Ltd.

Membership of Committees (April 2018-January 2019): Quality Assurance Committee, Oversight Committee

Membership of Committees (April 2018-January 2019): Quality Committee in common, Workforce Committee in common, Oversight Committee

Gaby Rydings, Non-Executive Director

Gaby is a qualified accountant who previously worked at the National Audit Office and the Parliamentary watchdog that audits public spending and evaluates the value for money of government projects and programmes. She was a member of the NAO Board for ten years with specific responsibility for policy, communications and relations with Parliament and Government.

Gaby lives in Leigh-on-Sea and is also a trustee and board member of Southend Association of Voluntary Services (SAVS).

Membership of Committees (April 2018-January 2019): Finance and Resources Committee, Charitable Funds Committee

Membership of Committees (April 2018-January 2019): Workforce Committee in common, Charitable Funds Committee

Tim Young, Non-Executive

Tim joined the Trust Board in December 2012. He has more than ten years' experience in the health sector and was also on the board of Essex Probation Service for nine years. He is a member of the labour party, Colchester borough council and Unite the Union and a Trustee of Firstsite Ltd and Greenstead Community Association. Tim is also director of Colchester Presents Community Interest Company and an Independent Director of North Essex Garden Communities Limited.

Tim took over the post of board champion for health and safety from 1 April 2013.

Membership of Committees (April 2018-January 2019): Quality Assurance Committee, Charitable Funds Committee, Remuneration and Nomination Committee

Membership of Committees (April 2018-January 2019): Quality Committee in common, Workforce Committee in common, Remuneration and Nomination Committee in common, Charitable Funds Committee.

Executive Directors

Clare Panniker, Chief Executive

Clare is joint Chief Executive of Southend University Hospital NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust and Mid Essex Hospital Services NHS Trust.

Prior to joining Basildon and Thurrock University Hospital, Clare was CEO of North Middlesex University Hospital for 9 years.

A registered nurse, Clare also has a business degree, and has worked in the NHS for more than 25 years.

Clare mentors other aspiring NHS leaders, from both clinical and management backgrounds. The Chief Executive is the Accounting Officer for the Trust and carries full responsibility for the Trust's performance, forward planning and leadership of the Executive Team and clinical directors.

Tom Abell, Chief Transformation Officer, Deputy Chief Executive

Tom Abell joined Basildon and Thurrock University Hospitals Foundation Trust in October 2015 as Deputy Chief Executive.

He was previously chief officer of NHS Basildon and Brentwood Clinical Commissioning Group. He is an important addition to the Trust board, bringing valuable experience of health commissioning.

Tom has been involved in several major service transformation and improvement programmes during his career. He has a special interest in the role that technology and new ways of working can play in improving health outcomes for patients, while making maximum use of valuable resources.

Yvonne Blücher, Managing Director

Yvonne joined Southend University Hospital NHS Foundation Trust in October 2015 as Chief Nurse from 'Barts' where she was Deputy Chief Nurse for Quality and Governance. Prior to this she spent 10 years as Director of Nursing and Quality at Princess Alexandra Hospital in Harlow, two years of which she was Director of Nursing and Operations Director.

She completed her nurse training and began her NHS career at Basildon Hospital before later specialising in cardiac care. She then moved north to Barnsley where she was instrumental in setting up first aid centres in the pit mines with defibrillators.

Yvonne is a fellow of the Institute of Health Improvement and has a real passion for engaging staff to ensure patients get the best possible outcomes.

Yvonne was appointed as the Managing Director in December 2016 as part of the Joint Executive Group, taking full responsibility for day-to-day operational business and leading on innovation and quality.

Martin Callingham, Chief Information Officer

Martin initially trained as a nurse at the Royal London Hospital, working in the A&E departments in and around North East London and Harlow. He made the move into site management and discharge planning service at Whipps Cross Hospital before moving to Newham as Head of Modernisation, implementing the first electronic patient records in 2004. He progressed to the role of Chief Information Officer at Newham responsible for IT, Information coding and data quality and following the merger of 'Barts' Hospital and Whipps Cross Martin was responsible for clinical systems across six hospital sites.

Martin joined Mid Essex Hospitals NHS Trust in August 2014 to help deliver, maintain and grow the use of technology and information across the Trust and to move towards a full Electronic Health Record in the near future.

Danny Hariram, Chief People & Organisational Development Director

Danny was previously the Workforce & OD Director at BTUH since 2015 and has worked in a number of acute and mental Health Trusts during the last twenty years with extensive experience of leading significant organisational change.

He works in ensuring high levels of staff engagement and works to develop an environment that allows for improvements for patients and staff, allowing staff the help and support to unlock their full potential.

James O'Sullivan, Chief Financial Officer

James joined Southend University Hospital NHS Foundation Trust as Chief Financial Officer in April 2014.

During his early career James qualified as an accountant while working in the oil industry. He has also worked in other sectors, latterly spending 18 years with EDF Energy, and has held a number of finance director roles over the years.

Immediately prior to joining the Trust he was a non-executive director at East Sussex Healthcare NHS Trust.

Diane Sarkar, Chief Nursing Officer

Diane's experience spans the NHS and private healthcare. After training at The Royal Free Hospital in London, she worked in a number of London's large acute hospitals and progressed through several operational and corporate management positions. In 1996, Diane worked in the private sector at the Wellington Hospital, setting up new governance frameworks and leading on the quality agenda.

Having completed a Master's degree, Diane returned to the NHS in 2001 at Southend Hospital, as Associate Director of Operations for Medicine and then Associate Director of Nursing. Appointed in 2010, her focus has been particularly around developing the nursing workforce, as well as leading on a number of corporate agendas, including quality improvement and the patient safety and patient experience agenda.

Celia Skinner, Chief Medical Officer

Celia obtained her Fellowship from the Royal College of Physicians in 2001 and has specialised in genito-urinary medicine, particularly the treatment of HIV/AIDS. She was previously Deputy Medical Director at 'Barts' Health where she had worked since 1995, having previously been Associate Medical Director and a Divisional Director. Celia is passionate about improving clinical care and sees the job of Medical Director here as an opportunity to build on her achievements at 'Barts'.

Eamon Malone, Chief Estates and Facilities Director

Eamon joined the MSB Group in December 2018 following a long Estates and Facilities career in the NHS in Northern Ireland. Eamon has experience leading estates services through a challenging merger process and utilising the skills, experience and expertise of Estates and Facilities colleagues to deliver more focussed and efficient services. Eamon is a Chartered Building Surveyor and a Fellow of the Institute of Healthcare Engineering and Estate Management.

Jonathan Dunk, Chief Commercial Officer

Jonathan joined the MSB Group in May 2018 to provide executive leadership to lead a variety of key strategic workstreams, including the future organisational form programme and the transformation of corporate support services. He has a strong background in finance, strategy and turnaround director roles, in both the NHS acute and commissioning sectors, most recently in the acute sector as Director of Finance at Milton Keynes NHS University Hospital. Jonathan is a graduate of the NHS Financial Management Training Programme and holds an NHS Leadership Academy Award in Executive Healthcare Leadership. Jonathan is a chartered accountant with CIPFA.

Directors who have served during the year but are no longer in office or on the Board

John Henry, Chief Estates and Facilities Director (interim, from September 2018 to December 2018)

John joined the Trust in June 2016 from NHS Property Services. During his early career John worked in the defence industry before switching to the Health Sector. He has subsequently worked within Estates and Facilities Management for 30 years for both private and NHS organisations. John's role covers Medical Equipment Management, Health and Safety, Fire Safety, Estates and Facilities Compliance, Decontamination Services, Sustainability, PFI and Commercials Services.

John is currently Director of Specialist Services across the MSB group and Senior Account Lead at Mid Essex hospital.

Paul Kingsmore, Chief Estates and Facilities Director (interim, from December 2017 to August 2018)

Paul was appointed on an interim basis whilst recruitment to a substantive postholder was taking place. Paul joined the Joint Executive Group in December 2017.

Prior to joining the group he was Director of Services at Manchester Metropolitan University from June 2017 to November 2017.

Paul is a Chartered Mechanical Engineer who undertook his engineering training at Short Brothers, Belfast. He joined the National Health Service in 1982 and has held a number of posts in the NHS in England, Scotland and Northern Ireland. He has been an executive director for over 17 years.

Paul has served on a number of national bodies including the Healthcare Associated Infection (HAI) taskforce in Scotland and the Department of Health's Patient Care Forum.

He is a past President of the Institution of Healthcare Engineering and Estate Management. He is currently also a director of HBE Ltd and First EFM Ltd.

Mary Foulkes OBE, Chief Human Resources Director (until November 2018)

Mary joined Southend University Hospital NHS Foundation Trust as Human Resources & Organisational Development Director in January 2015. She was appointed to the role of Chief Human Resources Director, Mid and South Essex Hospitals in February 2017.

Mary has over 25 years' experience at director level in a variety of private, public and third sector industries. This includes eight years working in the NHS in both the acute and mental health sector.

Mary is a Fellow of the Chartered Institute of Personnel and Development and was awarded an OBE in 2003 for her charitable work.

3.1.4 Site leadership team

Whilst the joint executives take a group-wide strategic view, the site leadership teams ensures that the leadership in each trust and the focus on its own unique challenges and opportunities is not compromised. The Trust's Managing Director is also a member of the JEG and is a non-voting member of the board of directors of the Trust.

The site leadership team comprised the following for 2018/19:

Yvonne Blücher – Managing Director

Louisa Cowell – Director of Finance

Clive Walsh - Director of Operations – Emergency & Unscheduled Care (May 2018 to January 2019)

Michael Quinn - Director of Operations – Emergency & Unscheduled Care (from January 2019)

Clare Burns – Director of Operations – Planned & Scheduled Care

Sue Bridge – Head of Human Resources

Neil Rothnie – Medical Director

Denise Townsend - Director of Nursing

James Fisher – Director of Transformation (until March 2019)

Brinda Sittapah – Company Secretary

3.1.5 Board composition, size and independence

The constitution sets the composition of the Board as the Chairman, up to seven non-executive directors, the Chief Executive, Chief Financial Officer and up to five executive directors. This ensures that there is an overall majority of non-executive directors. With effect from 1 February 2017, the members of the Joint Executive Group (JEG) became the executive members of the Board. These arrangements were in the form of secondments from the postholders' substantive roles until 31 March 2019. None of the executive directors currently hold any non-executive director positions in any foundation trust or similar sized organisation.

The non-executive directors have financial and/or commercial experience, existing knowledge of the NHS, educational backgrounds, voluntary and charitable sector experience.

It is considered that all the non-executive directors are independent in character and they are free from material business or other relationship which may interfere with their judgement.

The Board incorporates a mixture of skills, knowledge and experience which is considered suitable for the challenges facing its members.

The Trust operates not only within its constitutional framework but also its standing orders and standing financial instructions. Any changes to any of these key documents are approved by the Board of Directors, and in the case of the constitution, by the Board of Directors and the Council of Governors.

The appraisal process for individual board members is carried out annually and is based on the outcome of objective setting for both executive and non-executive directors. The outcome of non-executive appraisals is used to inform future development and is shared with governors.

The Senior Independent Director carries out the annual appraisal of the Chairman's performance, consulting with colleague non-executive directors, executive directors and governors.

The Board typically evaluates the performance and processes of its own committees on an annual basis and in accordance with procedures adopted by the board, to ensure its on-going effectiveness. It carries out a 'real time' evaluation of Board and Committee meetings with members selected in advance to provide feedback at the end of the meeting against a prompt sheet of key factors.

An internal Board Evaluation Exercise was conducted in February 2018 and the action plan was successfully implemented throughout the year. With the transition towards the boards in common and committees in common model explained in Section 3.1.2, it was agreed that a collaborative governance review will be undertaken in Summer 2019 to review the effectiveness of the new arrangements in place including the board and committee effectiveness.

Membership of the Board represents a significant time commitment and non-executive directors must be prepared to give sufficient time to perform their duties.

In accordance with the guidance set out in the Foundation Trust Code of Governance, arrangements have continued during 2018/19 for the Chairman and non-executive directors to meet outside the normal Board meetings.

3.1.6 Declaration of interest and Declaration of related party interest/Fit and Proper person test

On appointment, Board members are individually required to declare all their interests and their related party interests and these are renewed annually.

During the year none of the board members, or applicable parties related to them, has undertaken any material transactions with the Trust.

The Directors' Register of Interests, which is updated annually, is available on the Trust website at www.southend.nhs.uk/about-us/meet-the-team/trust-board-local-leadership-team/

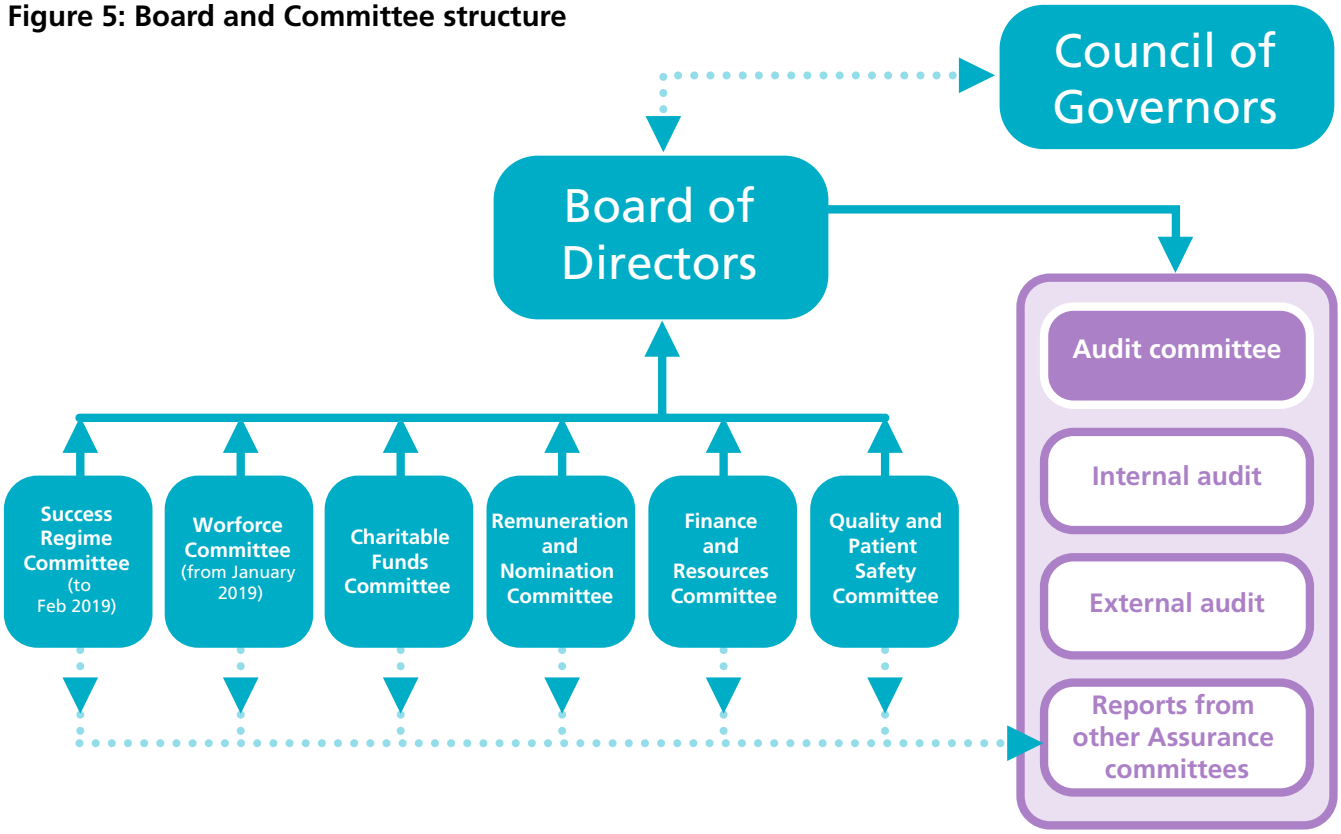
The Fit and Proper Regulations policy was adopted by the Board on 20 January 2016 and covers all existing and new director appointments. All Board members have been assessed against the requirements of the fit and proper person test.

3.1.7 Board and Committee structure

The Board of Directors has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. The Board of Directors keeps the performance of its committees under regular review and requires that each committee considers its performance and effectiveness throughout the year. These assessments, together with committee meetings, are used for shaping individual and collective professional development programmes for directors as relevant to their duties as Board members.

During 2018/19, the Trust's Board Committee structure was as set out overleaf in Figure 5.

Figure 5: Board and Committee structure



3.1.8 Trust Board meetings and Board Committees

The Trust Board held a total of five meetings between 1 April 2018 and 31 March 2019, two of which were held in common. Four of these meetings were held in public. The Trust also held four board development sessions during the year and as from January 2019 three Site Governance Forum meetings were held.

Audit Committee

The Audit Committee's responsibilities are set out in its terms of reference. Its main objective is to advise the Board of Directors and provide assurance through independent and objective reviews of the adequacy of the Trust's system of internal control, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation.

The committee meets quarterly during the year (with an additional meeting in May which focuses on the annual report and accounts) and its membership is made up of four non-executive directors with a quorum of three members. Membership was unchanged during the year. An assurance report is provided to each Board meeting following the Audit Committee.

Audit Committee Annual Report

Introduction

In line with the recommendations within NHSI's published audit code, all foundation trusts are required to present an annual report on the activities undertaken during the year, drawing particular attention to the nature of the reports received from both internal and external auditors. This report is presented to the Council of Governors.

Mike Green and David Parkins can be considered to have relevant financial experience. All members can be considered to be independent.

The committee is supported by the Site Leadership Team. The Chief Finance Officer (assisted by members of the finance team), Head of Internal Audit and a representative from the external auditors attend all meetings. The Local Counter Fraud Specialist attends at least two meetings per year. Other site directors are invited to attend on a regular basis, particularly when the committee is discussing operational issues that are their direct responsibility.

Governors may attend committee meetings by invitation as observers. The committee chairman is available for governors to talk about audit matters and the committee's work, if they wish. Ahead of each committee meeting, the chair holds a private meeting with the NEDs at which they discuss any particular items that they wish to raise during the meeting. At the end of each meeting a private session is held with the auditors, both internal and external without executive members present. These private sessions enable the committee to discuss matters directly with the audit teams.

Committee Responsibilities and how they were discharged in 2018/19

The committee ensures that the organisation establishes and maintains effective systems of risk management and internal control that support the achievement of the Trust's objectives. The committee was supported in this duty by the Quality Assurance Committee until 31 December 2018 and now by the Quality Committee in Common, which has responsibility for providing assurance that there is an effective system of risk management and internal control across the clinical activities of the organisation that support the Trust's objective to provide high quality care for every patient, every time. It was a requirement until 31 December 2018 that the Chairs of the Audit Committee and the Quality Committee to serve on each other's committees. From 1 January 2019 it is a requirement that a member of the Trusts Audit Committee serves on the Quality committee in common – Fred Heddell fulfils this role.

In addition to significant responsibilities regarding internal and external audit, the committee also has responsibilities regarding financial reporting and financial governance, with particular emphasis on the annual governance statement. The committee also reviews the annual financial statements before submission to the Trust Board and regularly reviews counter fraud issues and the activities of the local counter-fraud specialist.

The committee chairman presents a report to the Board after each Audit Committee meeting summarising the issues discussed and the assurances received together with any matters that require the consideration of the Board.

The committee's terms of reference, which were reviewed during the year, are available on our website at http://www.southend.nhs.uk/about-us/trust-publications-and-reports/trust-board-committees/

The main matters and areas of judgement reviewed and considered during 2018/19 were as follows:

Internal Controls

To discharge the responsibility to review the effectiveness of the Trust's internal controls, the Committee:

- Reviewed the internal audit plan for 2018/19
- Reviewed the reports produced by internal audit and ensured management had plans to address any control weaknesses identified and that those plans, and any outstanding issues, were dealt with on a timely basis. Specific areas of focus in the year were:
    - Recruitment and Retention
    - Medicines Management
    - Emergency Planning
    - Estates Management – Capital Programme
    - GDPR Compliance Audit
    - Patient Experience
    - Workforce Utilisation – eRostering
    - Key Finance Systems
    - DSP Toolkit
    - BAF & Risk Management
    - Mandatory Training
- Reviewed the external audit plan by BDO LLP for the year ending 31 March 2019
- Reviewed the LCFS workplan for 2018/19, received reports from the Local Counter Fraud Specialist on a programme of proactive work and any potentially fraudulent activity from both within and outside the Trust and discussed management's plans to prevent recurrence and approved the LCFS workplan for 2019/20
- Reviewed the waiver reports on a quarterly basis and ensured management had plans to address the issues relating to retrospective waivers raised by specific departments
- Considered a report on the returns and waste management of drugs across the three Trusts
- Reviewed the process for identifying overseas patients and suggested for relevant KPIs to be implemented
- Reviewed the declaration of interest register, APBI data and the gifts and hospitality register
- Reviewed the Corporate Risk Register
- Sought particular assurance on the cyber security risks facing the Trust
- Reviewed a report highlighting the measures put in place to reduce agency premium rate working
- Reviewed the Information Governance Report and IG breaches
- Reviewed the Reference Costs Process for the 2018/19 Submission

Financial Reporting and Significant Financial Judgements

The committee assessed whether suitable accounting policies had been adopted, whether management had made appropriate estimates and judgements and whether disclosures were balanced and fair. The main areas of focus in 2018/19 and matters where we specifically considered the judgements that had been made are set out below:

- Going concern
- Fair value of property plant and equipment
- Accounting for recharges
- Implementation of new financial reporting standards relating to financial instruments and revenue recognition

The committee reviewed the Annual Report and Accounts with a specific focus on:

- The Annual Governance Statement
- The Remuneration Report
- Value for money conclusion
- Application of the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis

Internal Audit

The Committee monitored and reviewed the activities of the internal auditor TIAA including monitoring independence and objectivity by:

- Reviewing changes to the internal audit plan, the reasons for the change and resource allocation.
- Receiving KPIs relating to delivery of reports and follow up.

The Head of Internal Audit opinion, based on the work undertaken in 2018/19, concluded that the organisation has adequate and effective management, control and governance processes to manage the achievement of its objectives.

A number of enhancements to the frameworks were recommended during the year and the committee receives a report at each meeting on the progress of implementation. The whole Board is collectively accountable for maintaining a sound system of internal control and for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

TIAA's contract for internal audit ended on 31 March 2019 and a limited OJEU (the Official Journal of the European Union) Framework Tender process was conducted during January 2019 following which RSM was awarded the contract for internal audit and LCFS across the three Trusts, for 3 years from 1 April 2019. The internal audit plan for 2019/20 will be presented to the Audit Committee meeting in May 2019.

External Audit

The effectiveness and independence of BDO LLP our external auditor is monitored and reviewed by the committee by an annual assessment questionnaire which was completed in July 2018 by committee members and senior staff and the results were discussed with the external auditors.

The auditors are also required, under professional standards, to confirm their independence both before and after the audit engagement.

Audit Committee Effectiveness

The committee undertakes an annual self-assessment of its effectiveness through a questionnaire distributed to the committee members. The outcomes of the self-assessment are discussed at a subsequent committee meeting. There were no issues arising out of this year's self-assessment and it was agreed by the committee that the next assessment will be extended to include the views of internal auditors, external auditors as well as staff.

The committee also carries out a 'real time' evaluation at each committee meeting with members selected in advance to provide feedback at the end of the meeting against a prompt sheet of key factors.

The committee members participated in on-going training during the year.

Priorities for 2019/20

For 2019/20, the committee will focus on:

- obtaining increased assurance levels from the new internal auditor, RSM on the consistency of internal audit reviews across the three Trusts as well as focussing on Trust specific audits and the speed of resolution of outstanding issues
- the work the external auditor will be undertaking
- increased assurance levels from the LCFS, RSM on managing fraud and bribery
- the arrangements to reconfigure corporate functions having due regard to the maintenance or strengthening of the control framework
- the risks outlined within the due diligence reports and mitigations in place and
- the risks associated with the delivery of the merger

Finance and Resources Committee / Finance and Performance Committee in Common

The Finance and Resources Committee (FRC) responsibilities are set out in its terms of reference. The committee provides the Board with assurance on the Trust's management of its resources (including financial, physical, human and information). The committee operates at a strategic level as the executive is responsible for the day-to-day operational delivery and management.

As from January 2019, the Finance and resources (Performance) committees of each Trust met only in common. The Finance & Performance (F&P) Committee in common responsibilities are set out in its terms of reference. The committee provides scrutiny of financial, estates, IT and operational performance in order to provide assurance and make recommendation, as appropriate, to the three Trusts Boards. Its membership is made up of three non-Executive Directors from each Trust, chief executive/deputy chief executive, chief finance officer, chief estates and facilities officer, chief information officer, chief commercial officer, group director of planning and performance and the managing directors. The Chief People & OD director and the site directors of finance are in attendance at the meeting. The quorum is nine members, including at least two non-executive directors from each trust, the Chief Executive or Deputy Chief Executive, the Chief Financial Officer or a delegated representative and one other Executive Director. An assurance report is provided to each Board meeting following each meeting.

The committee met eight times during the 2018/19 financial year, four of which were held in common.

Quality Assurance Committee / Quality Committee in Common

The Quality Assurance Committee (QAC) responsibilities are set out in its terms of reference. The committee assures the Board that there is an effective system of risk management and internal control across the clinical activities of the organisation that support the organisation's objectives and the Trust's ability to Care with Compassion. There are a number of committees and groups having responsibility for quality governance matters that report regularly to QAC by exception, thus providing comprehensive accountability arrangements within the Trust and these include the Corporate Governance Group, the Corporate Management Team, the Clinical Governance Committee, the Quality and Safety Committee, the Equality and Diversity Committee and the Health & Safety Committee. From January 2019, these committees/groups report on an exception basis to the Site Governance Forum.

As from January 2019, the Quality Assurance Committee of each Trust met only in common. The Quality Committee (Qc) in common responsibilities are set out in its terms of reference. The committee functions as the Trust's umbrella clinical governance committee, providing the Trust Board with assurance that the Trust is delivering a quality service against each of the dimensions of quality set out in High Quality Care for All and enshrined in the Health and Social Care Act 2012. Its membership is made up of three Non-Executives from each Trust, Chief Executive, Chief Nursing Officer, Chief Medical Officer and managing directors. The site medical directors and directors of nursing are in attendance at the meeting. The quorum is six non-executive directors of whom at least two will be non-executive directors from each trust, plus at least one of the Chief Executive, Chief Nursing Officer, Chief Medical officer or managing director. An assurance report is provided to each Board meeting following each meeting.

The committee met six times during the 2018/19 financial year, one of which was held in common.

Workforce Committee in common

The workforce committee in common (Wc) responsibilities are set out in its terms of reference. The committee provide assurance to the three Trust Boards on the development and delivery of the MSB strategy for a sustainable workforce in line with the NHS Long Term Plan. The People & OD strategy includes recruitment and retention to improve sustainable workforce numbers, horizon scanning for intelligence to increase the adoption and spread of innovative workforce models, implementing innovative ways of working and skills acceleration, taking systematic

approaches to the management of change and staff engagement and culture change. Its membership is made up of three non-Executive directors from each Trust, Chief Executive/Deputy Chief Executive, Chief People & OD Director or delegate, Chief Nursing Officer or delegate, Chief Medical Officer or delegate and Managing Directors or delegate. The site heads of HR, Group Director of Workforce strategy, Group Director of Resourcing and planning, Group Director of OD, Communications Director and Group Director of Medical Education are in attendance at the meeting. The quorum is eight members, including at least two non-executive directors from each trust, the Chief People & OD Director or nominated deputy and one other Executive Director. An assurance report is provided to each Board meeting following each meeting.

The committee met twice during the 2018/19 financial year.

Charitable Funds Committee

The Charitable Funds Committee exists to carry out the functions delegated to it by Southend University Hospital NHS Foundation Trust, which is the Corporate Trustee of the Charity that is registered with the Charity Commission as Southend University Hospital NHS Foundation Trust Charity.

The Corporate Trustee, through its board, has delegated day-to-day management of the charity, including delegable functions as defined in the Trustee Act 2000, Section 11, to the committee. Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee responsibilities are set out in its terms of reference. An assurance report is provided to each Board meeting following the Committee meeting.

The Committee meets three times a year and its membership is made up of four members of the Corporate Trustee, excluding the Chief Financial Officer of the Trust. The quorum is two members of the Corporate Trustee, excluding the Chief Finance Officer. Membership was unchanged during the year.

Remuneration and Nominations Committee

The responsibilities of the Remuneration and Nominations Committee are set out in its terms of reference. This Committee serves two key purposes in relation to remuneration and nomination:

Remuneration

- Determine the remuneration and terms of service of the Chief Executive, Executive Directors, the Trust's Managing Director and Site Directors.
- Consider the payment conditions of any termination arrangements.

Nomination - to support the Chairman in ensuring that the Trust is led by an effective Board of Directors by:

- Making appointments of Executive Directors (including the Chief Executive), the Trust's Managing Director, the Trust's Site Directors following formal, rigorous and transparent processes.
- Advising the Council of Governors on the skills and experience required for Non-Executive Director appointments.

The Committee consists of six non-executive directors. The quorum is four members. Each member of the committee is considered to be independent and none has a personal financial interest in the committee's decisions. The Chief Executive, the director of Human Resource and the Chief Human Resources director are invited to attend the committee when relevant. Neither will attend any meeting at which the terms of office or remuneration for their posts are under discussion. Membership was unchanged during the year.

Committee annual self-assessment

Committees undergo an annual self-assessment, with all members contributing. The evaluations are considered by each committee and reported at a subsequent meeting, with agreed action being taken to address issues where required.

3.1.9 Directors' attendance

Membership and attendance at Board of Directors and committee meetings is summarised below. The values shown are the number of attendances against the number of meetings held during the year that the director was eligible to attend. Where there is no entry, this means that the director is not a member of that Committee.

Table 4: Attendance at meetings, Directors

Board/Committee	BoD/ BoDc	AC	FRC/ F&P	QAC/ Qc	CFC	RNC/ RNCc	Wc
Chair	Alan Tobias (SUHFT)	Mike Green (SUHFT)	David Parkins (SUHFT)	Fred Heddell (SUHFT)/ Karen Hunter (MEHT)	Fred Heddell (SUHFT)	Tony Le Masurier (SUHFT)/ Nigel Beverly (BTUH)	Barbara Stuttle (BTUH)
Alan Tobias OBE	5/5	_	2/4	1/2	_	4/5	2/2
David Parkins	4/5	3/4	7/8	5/5	_	4/5	-
Mike Green	4/5	4/4	8/8	5/5	_	5/5	-
Fred Heddell CBE	4/5	2/4	_	7/7	2/2	4/5	-
Tony Le Masurier	5/5	4/4	8/8	_	_	5/5	-
Gail Partridge	3/5	_	4/4	7/7	_	_	2/2
Gaby Rydings	4/5	_	4/4	_	1/2	1/1	2/2
Tim Young	4/5	_	_	6/7	2/2	4/5	1/2
Clare Panniker	3/5	_	3/4	2/2	_	_	1/2
Tom Abell	5/5	_	2/4	_	_	_	1/2
James O'Sullivan	5/5	_	7/8	_	_	_	-
Diane Sarkar	3/5	_	_	2/2	_	_	1/2
Celia Skinner	3/5	_	_	1/2	_	_	0/2
Yvonne Blücher	3/5	_	6/8	2/2	1/2	_	1/2
Martin Callingham	5/5	_	4/4	_	_	_	-
Mary Foulkes	2/2	_	_	_	_	_	-
Jonathan Dunk	3/3	_	4/4	_	_	_	-
Eamon Malone	2/3	_	4/4	_	_	_	-
Danny Hariram	2/2	_	_	_	_	_	2/2
Paul Kingsmore	1/1	_	1/1	_	_	_	-
John Henry	2/2	_	1/1	_	_	_	-

Key:

(BoD) Board of Directors
(AC) Audit Committee
(FRC) Finance and Resources Committee
(QAC) Quality Assurance Committee
(CFC) Charitable Funds Committee
(RNC) Remuneration and Nominations Committee
(BoDc) Board of Directors in Common
(F&Pc) Finance & Performance Committee in Common
(Qc) Quality Committee in Common
(Wc) Workforce Committee in Common
(RNCc) Remuneration & Nominations Committee in Common
(SUHFT) Southend University Hospital NHS Foundation Trust
(MEHT) Mid Essex Hospital Service NHS Trust
(BTUH) Basildon & Thurrock University Hospital NHS Foundation Trust

3.1.10 Council of Governors

The role of the Council of Governors

Governors represent the interests of the Trust's public and worker constituencies, as well as its partner organisations in the community.

The Council of Governors has a number of statutory duties, defined in the constitution, which include:

- appointing and removing the non-executive directors, including the Chairman at a general meeting.
- deciding the remuneration and allowances and the other terms and conditions of office, of the non-executive directors.
- appointing and removing the Trust's external auditor at a general meeting.
- approving the appointment (by the non-executive directors) of the Chief Executive.
- receiving and giving their view on plans from the Board of Directors regarding the future development of the Trust.
- receiving at a general meeting, copies of the Trust's annual accounts, auditor's reports and annual reports.
- holding the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- representing the interests of Trust members and the public in the governance of the NHS Foundation Trust. Governors must act in the best interests of the NHS Foundation Trust and should adhere to its values and code of conduct.
- feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them.

The Council of Governors holds formal meetings in public to make decisions and to ensure the views and priorities of local people inform the Trust's decisions on strategy. In addition, governors hold meetings without officers present to discuss matters amongst themselves and attend informal meetings with directors to develop their own knowledge of Trust services and discuss issues as they arise.

During 2018/19, many of the Trust's governors have attended the regular evening and afternoon events where they can engage with Trust members and members of the public. These meetings also provide the opportunity for asking the public a wide variety of questions about their experiences at Southend University Hospital. In addition, the governors also issue a regular newsletter to all the members, The FuTure, which keeps them informed of hospital and membership matters.

Council of Governors and its relationship with the Board of Directors

The Council of Governors also has a statutory duty to hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors. Throughout the year, the Council has been briefed on the Trust's future strategy, its operational performance and how the Trust looks after its patients to ensure that it is provided with the information required to fulfil its duty, as well as progress on the work being undertaken across the three Trusts.

As part of the continuing cooperation between the board and the council, governors are encouraged to attend the Trust's Board Meetings and Board Meetings in common held in public. Governors are invited to attend the Audit Committee meetings and the Quality Assurance Committee meetings, neither of which is open to the public. Governors are also invited to attend the Clinical Governance Committee and the Quality and Safety Committee which report to the Quality Assurance Committee by exception. The Vice Chair of Governors is also invited to attend meetings of the directors' Nomination Committee. The Vice Chair and Lead Governor of the Council of Governors are invited to attend part two of board meetings.

To ensure that they understand the views of the governors in their statutory role of representing the interests of the members of the Trust as a whole and the interests of the public, members of the Board of Directors, particularly the non-executive directors have engaged in the following measures:

- regular attendance at Council of Governor meetings
- acting as NED liaison on governor committees
- attending the Non-Executive Directors and Governors Group (NAGG)
- conducting ward walk rounds together with one or two governors

The governors have also taken part in 'listening exercises' in the hospital and its clinics to solicit the views of patients, members and visitors to the hospital.

The Trust has in place arrangements covering the process for the appointment of the chairman and non-executive directors. These arrangements cover the following responsibilities:

- The Board of Directors will identify the balance of individual skills, experience and knowledge it requires at the time a vacancy arises for the non-executive directors (including the Chairman).
- A job description and person specification is drawn up for each occurrence of new appointments.
- Under the Trust's constitution, governors can extend the Chairman and non-executive directors' term of office. This power was exercised by the Council of Governors in February 2018 and subsequently in September 2018 and it was agreed to extend the term of office of the Chairman and all Non-Executive Directors until April 2020 when it is expected that the three Trusts will merge. This transitional arrangement will be further reviewed in June 2019.
- In circumstances, when open competition is applicable, appropriate candidates will be identified through a process of open competition by the governors' search and appointments committee.
- The Search and Appointments Committee will have responsibility for handling all further aspects of the recruitment process, including the arrangement of 'meet the candidate' days when executive and non-executive directors are invited to meet the candidates, together with the governors, and provide their views to the final interviewing panel.
- In the case of the appointment of a chairman, an independent third party (non-voting) will sit on the final interview panels.
- The Search and Appointments Committee will make recommendations to the council of governors who shall appoint the non-executive directors.
- Any re-appointment of a non-executive director shall be subject to a satisfactory appraisal carried out in accordance with procedures which the council of governors have approved.

The regular attendance at Council of Governor meetings by both non-executive directors and executive directors provides an excellent opportunity for governors to raise and discuss any issue which they feel is important to their role.

The Schedule of Matters reserved for the Board details the decisions and responsibilities reserved to the Council of Governors, the Board of Directors and those delegated to the agreed committees of the Board of Directors. In the event of any unresolved dispute between the Council of Governors and the Board of Directors, the Chairman or the Company Secretary may arrange for independent professional advice to be obtained for the Trust. The Chairman may also initiate an independent review to investigate and make recommendations in respect of how the dispute may be resolved. The overall responsibility for running an NHS foundation trust lies with the Board of Directors. The Council of Governors is the collective body through which the directors explain and justify their actions; the council should not seek to become involved in the running of the Trust.

Composition of the Council of Governors

Members of the Trust are able to elect representatives of 16 years of age and above from their membership constituencies to serve on the Council of Governors. In addition, specific partnership organisations may also appoint representatives to the Council of Governors.

Elected governors may hold office for three years but are eligible for re-election at the end of their first term. In accordance with the constitution, they may not hold continuous office for a period of longer than six years, which must be followed by a two-year break before standing for re-election. However, in view of the proposed merger, the council of governors agreed to extend some of the governors' terms of office who were due to come to an end during the year and this necessitated a change in the constitution.

Appointed governors may hold office for three years but are eligible for re-election at the end of their first term and second terms. In accordance with the terms of the constitution, they may not hold office for a continuous period of longer than nine years.

The Council of Governors comprises **28 governors** for 2018/19 with further 4 positions currently vacant.

The following table shows the composition of the Council of Governors.

Table 5: Composition of the Council of Governors

Group		Number of Governors	Vacant Positions
Elected	Southend constituency	7	1
	Castle Point constituency	4	
	Rochford constituency	2	2
	Rest of Essex	2	1
Worker	Southend Hospital and treatment centre class	3	
	Britannia House and satellites clinics class	1	
	Volunteer worker elected by volunteer workers in the volunteer worker class.	1	
Local Authority	Southend Borough Council	1	
	Castle Point Borough Council	1	
	Rochford District Council	1	
	Essex County Council	1	
Partnership Organisations	Anglia Ruskin University	1	
	Essex University	1	
	Southend Association of Voluntary Services	1	
	Southend Hospital Charitable Foundation Trust	1	
Total		**28**	**4**

Council of Governors' Meetings

The Council of Governors meets at least four times per year, plus the Annual General Meeting, and this is considered sufficient to fulfil its duties. Attendance at the Council of Governors is shown in Tables 6 and 7 for governors and Table 8 for Board members.

Table 6: Attendance at meetings, elected Governors

Governor	Constituency	Type	Tenure	Attendance at council meetings
Rachel Clark[1]	Castle Point	Public	Elected in August 2015 for 3 years	3/3
Linda Cook[1]	Southend	Public	Re-elected in August 2015 for 3 years	2/3
Nigel Gayner[1]	Southend	Public	Elected in August 2015 for 3 years	1/3
Nirmal Gupta MBE[1]	Southend	Public	Elected in August 2015 for 3 years	2/3
Frank Haysom[1]	Southend	Public	Elected in August 2015 for 3 years	3/3
Barbara Oliver[2]	Rochford	Public	Elected in August 2015 for 3 years	2/3
Vivien Burling	Castle Point	Public	Elected in August 2016 for 3 years	2/3
Les Catley	Rochford	Public	Re-elected in August 2016 for 3 years	2/3
Lawrence Collin	Southend	Public	Re-elected in August 2016 for 3 years	2/3
Joe Cooke	Castle Point	Public	Re-elected in August 2016 for 3 years	2/3
Sally Holland	Southend	Public	Elected in August 2016 for 3 years	3/3
Chima Okorafor	Rest of Essex	Public	Elected in August 2016 for 3 years	1/3
Brian Terry	Castle Point	Public	Elected in August 2016 for 3 years	2/3
Laura Hilton	Hospital Site	Worker	Elected in August 2016 for 3 years	3/3
Ted Lewin	Hospital Site	Volunteer Worker	Elected in August 2016 for 3 years	2/3
Judith Craven	Rest of Essex	Public	Elected in August 2017 for 3 years	2/3
Liz Leigh	Southend	Public	Elected in August 2017 for 3 years	2/3
Miriam Schramm	Rochford	Public	Elected in August 2017 for 3 years	2/3
Stephanie Carey	Hospital Site	Worker	Elected in January 2019 for 3 years	1/1
Jesudass Johnselvan	Hospital Site	Worker	Elected in December 2018 for 3 years	1/1
Chris Walkden	Hospital Site	Worker	Elected in January 2019 for 3 years	0/1

[1] A decision was made to extend the term of office until April 2020. Arrangement to be reviewed in June 2019
[2] Retired/resigned during the 2018/19 financial year

Table 7: Attendance at meetings, appointed Governors

Governor	Constituency	Type	Tenure	Attendance at council meetings
Pam Challis[1]	Castle Point Borough Council	Local Authority	Appointed in June 2015	1/1
Meg Davidson[1]	Southend Borough Council	Local Authority	Appointed in September 2016	0/3
Sarah Lee	Essex University	Partnership	Appointed in September 2016	0/3
Terry Cutmore	Essex County Council	Local Authority	Appointed in September 2016	0/3
Mick Thwaites	Southend Hospital Charitable Foundation Trust	Partnership	Appointed in September 2015	1/3
Melanie Bird	Anglia Ruskin University	Partnership	Appointed in September 2016	0/3
John Lamb	Southend Association of Voluntary Services (SAVs)	Partnership – Voluntary sector	Appointed in September 2015	0/3
Mike Webb[1]	Rochford District Council	Local Authority	Appointed in May 2017	0/0
Denis Garne[2]	Southend Borough Council	Local Authority	Appointed in May 2018	1/3
Bill Sharp[1,2]	Castle Point Borough Council	Local Authority	Appointed in May 2018 (resigned in October 2018)	0/1
Julie Gooding[2]	Rochford District Council	Local Authority	Appointed in May 2018	3/3
Pat Haunts[2]	Castle Point Borough Council	Local Authority	Appointed in October 2018	0/2

[1] Retired/resigned during the 2018/2019 financial year
[2] Appointed during the 2018/19 financial year

Table 8: Attendance at meetings, Board members

Board members	Positions	Attendance at council meetings
Alan Tobias OBE	Chairman	3/3
David Parkins	Non-Executive Director	2/3
Mike Green	Non-Executive Director	1/3
Fred Heddell CBE	Non-Executive Director	1/3
Tony Le Masurier	Non-Executive Director	2/3
Gail Partridge	Non-Executive Director	3/3
Gaby Rydings	Non-Executive Director	1/3
Tim Young	Non-Executive Director	1/3
Clare Panniker	Chief Executive	1/3
Tom Abell	Chief Transformation Officer	1/3
James O'Sullivan	Chief Finance Officer	1/3
Diane Sarkar	Chief Nurse	1/3
Celia Skinner	Chief Medical Officer	1/3
Yvonne Blücher	Managing Director	2/3
Martin Callingham	Chief Information Officer	0/3
Mary Foulkes OBE	Chief Human Resources Director	0/1
Paul Kingsmore	Interim, Chief Estates and Facilities Director	0/1
Jonathan Dunk	Chief Commercial Officer	1/3
Eamon Malone	Chief Estates and Facilities Director	0/3
Danny Hariram	Chief People & Organisational Development Director	0/3
John Henry	Interim, Chief Estates and Facilities Director	0/1

3.1.11 Council of Governors Committees/Groups

The Council of Governors also has a number of committees and sub-groups to carry out its function, and these are described below.

Strategy & Governance Group

This group meets to discuss a wide range of strategy and governance matters and advises the Council of Governors accordingly.

Topics considered include surveys of governors conducted by organisations such as NHSI and NHS Providers, the council of governors' self-assessment and governor elections. The committee makes recommendations on the appointment or removal of the Trust's external auditors taking into account the views of the Audit Committee. It also monitors the application of the constitution and reviews the wording of the governors' code of conduct to ensure that it continues to be appropriate. On behalf of the Council of Governors, the group considers forward planning issues and makes recommendations.

Membership Engagement and Recruitment Group

This group looks at ways of communicating and engaging with members of the Foundation Trust and encouraging patients, carers and members of the public to join the Trust. It is also the group which networks with other foundation trusts and monitors and receives reports from NHS Providers before consideration by the Council of Governors. This group also agrees the content of the governors' newsletter which is sent to members of the Trust. The group also reviews the education and training needs of governors to enable them to fulfil their role as fully as possible, and makes recommendations to the Council of Governors.

Patient and Carer Experience Group

This group consider how the Trust meets the healthcare needs of the people served by the Trust. It participates in projects to obtain the views of patients and carers and receives information about hospital services directly from patients, carers and nursing staff, amongst other sources. In addition to reviewing the wider needs of patients and carers it also considers how the hospital provides services to specific groups such as children and younger persons, and older people.

Search and Appointments Committee

The Council of Governors is responsible for appointing the chairman and non-executive directors and is made up of governors and the Chairman (unless the Chairman's post is being appointed to).

This committee will take into account the advice of the Nominations Committee in reviewing the structure, size and composition of the Board of Directors. It gives full consideration to succession planning for the Chairman and other non-executive directors, identifies and nominates suitable candidates and reviews the remuneration, allowances, other terms and conditions of office. The committee makes recommendations to the Council of Governors regarding chairman and other non-executive directors' appointments.

Worker Governors' Group

Worker governors have attended staff team meetings in a variety of departments across the Trust.

NEDs and Governors' Group

The NEDs and Governors' Group allows for the consideration and exchange of views, opinions, interpretations and understanding of information provided to governors by the Board of Directors so that the governors may fulfil their duty of holding the non-executive directors to account for the performance of the Board. The meetings are less formal than Council of Governor meetings, although matters raised at it are escalated to other governor committees for resolution or action.

Governors' interests

A register of governors' interests is maintained by the Company Secretary and may be viewed on the hospital website at www.southend.nhs.uk/about-us/meet-the-team/council-of-governors/

3.1.12 Membership of the Trust

Our members must be 12 years of age and above and are able to elect representatives of 16 years of age and above to the council of governors. Through our governors, they receive information about the Trust, and are consulted on plans regarding the future development of the Trust and its services. We strive to ensure that our membership reflects the full diversity of the local population.

Eligibility to become a Southend University Hospital NHS Foundation Trust member is based on criteria as described below.

Public members

These are based on local authority areas in the immediate vicinity (Southend, Castle Point and Rayleigh & Rochford, with a separate constituency for the 'rest of Essex').

Volunteer worker members

This category is for our hospital volunteers.

Worker members

Members of the worker constituency are individuals who:

- are employed under a contract of employment by the Trust; or
- are not so employed but who nevertheless exercise functions for the purposes of the Trust; and
- who satisfy the minimum duration requirements set out in paragraph 3(3) of Schedule 1 to the 2003 Act;
- who are not disqualified from becoming a member and have either made an application for membership, or have received an invitation from the Trust to become a member and have now informed the Trust that they do not wish to do so.

At 31 March 2019, our total FT membership stood at 21,219 (31 March 2018 =21,490), made up of:

- Public members = 16,237 (31 March 2018 = 16,588)
- Volunteer workers = 384 (399)
- Workers = 4,598 (4,503)

Our membership objectives

1. To focus on developing and maintaining effective meaningful engagement with our members and the public.
2. To ensure that our membership better reflects the demographic of south Essex by increasing our membership in under-represented areas.
3. To ensure our members, and the public at large, are actively involved in shaping future services at Southend University Hospital.
4. To measure the effectiveness of the membership engagement strategy and to ensure resources are deployed to achieve maximum benefit.

If you would like to receive information about becoming a member, call on Freephone number 0800 0185202, email to foundation.members@southend.nhs.uk or write to the Membership Manager, Communications Department, The Lodge, Southend University Hospital NHS Foundation Trust, FREEPOST ANG1863, Prittlewell Chase, Westcliff-on-Sea, Essex SS0 0RY.

Consulting with our members

During the 2018/19 financial year, the governors, supported by Trust staff, took part in 20 community engagement events, including visits to schools; careers fairs; mock interviews; fresher's fairs and other related activities in order to promote the Trust, canvass views about the issues of importance to members, and gain feedback on the Trust's future plans and strategies. A full list of events can be found at Appendix 2.

3.1.13 Compliance with cost allocation

The directors confirm that the Trust complies with the cost allocation and charging guidance issued by HM Treasury.

3.1.14 Details of any political donations

The directors confirm that there have been no declarations of donations to political parties.

3.1.15 Better payment practice code

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

In recent years the Trust had been unable to consistently achieve the 30-day payment measure mainly as a consequence of the pressure on our operating cash resources.

Performance against the code is set out in Table 9.

Table 9: Performance against Better Payment Practice Code

	2018/19 Volume	2018/19 Value £'000	2017/18 Volume	2017/18 Value £'000
NHS – Paid in Year	1,751	18,976	2,001	24,926
NHS – Paid within Target	787	8,134	1,282	18,983
NHS - % paid within Target	44.9%	42.9%	54%	76%
Non NHS – Paid in Year	74,133	129,593	80,533	122,380
Non NHS – Paid within Target	39,863	77,625	64,205	99,966
Non NHS - % paid within Target	53.8%	59.9%	80%	82%

3.1.16 Disclosures relating to NHS Improvement's well-led framework

The Trust's approach to ensure services are well led is discussed in detail in the earlier section of this Director's report and in the Annual Governance Statement.

A review of the well-led framework was carried out internally in 2017 prior to the formal routine inspection of the well-led domain by the Care Quality Committee. The review was carried out using the NHS Improvement's well-led framework around the eight key lines of enquiry (KLOEs) and was undertaken using a variety of methods. These methods included a review of policies and procedures, review of meeting minutes and papers, observations at meetings and interviews with senior leaders both at corporate and directorate level. In addition to the trust level review against the well-led KLOE's, a review of clinical areas was carried out in September 2017 which looked at all 5 CQC domains (Safe, Effective, Caring, Responsive and Well-led) and a rating was applied to each area visited using the CQC ratings framework against the evidence obtained. Action plans were developed for each area against the findings of the review and these were monitored at the weekly 'maintaining high standards' meeting to ensure governance and quality improved.

An internal well led review will take place in 2019/20 to ensure we remain compliant with the well led framework.

Details of the internal control systems in place to manage and control risks in addition to the trust quality governance structure can be found in more detail within the annual governance statement.

3.1.17 Income disclosures

It is confirmed that, as required by section 43(2A) of the NHS Act 2006, the income the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose.

It is confirmed that, as required by section 43(3A) of the NHS Act 2006, the other income which the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

3.1.18 Statement as to disclosure to Auditors

For each individual who is a director at the time that the report is approved:

- So far as the director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware;
- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information; and
- The director has taken all the steps that they ought to have taken as a director to establish that the NHS foundation trust's auditor is aware of that information.

Clare Panniker
Chief Executive
29 May 2019

3.2 Remuneration report

'Senior managers' are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. For the purposes of this report, the term 'senior manager' applies to the Chair, non-executive directors and all executive directors.

3.2.1 Annual statement from the Chair of the Remuneration and Nominations Committee

It is a statutory requirement that the Trust has a Remuneration and Nominations Committee. The committee has delegated responsibility for determining remuneration for all executive directors, including pension rights and any other compensation payments.

It is a fundamental requirement for the Trust to be well led by executives able to demonstrate high standards of strategic leadership, as well as skill and experience in operational, clinical, financial and people matters.

The committee must satisfy itself that the remuneration levels support the achievement of the Trust objectives. The committee, within its terms reference, establishes and keeps under review a remuneration policy in respect of executive directors (including the Chief Executive). The policy is to pay market rates whilst ensuring that the Trust makes proper use of public money. The committee must approve the submission of proposals to HM Treasury, for payments which exceed contractual obligations where applicable. The committee meets as required but ideally twice a year. The committee chairman reports formally to the Board after each meeting.

As part of the collaborative governance arrangements the Remuneration and Nominations Committee of the three trusts continued to meet and transact their business in common during the year.

The Remuneration and Nomination Committee in Common retained their own terms of reference and accountability to their own Trust Board by whom their authority was delegated.

During 2018/19, the Remuneration and Nomination Committee in Common met on three occasions. At these meetings, the following items of business were transacted:

- The objectives for the executives, including the Chief Executive, were discussed, refined by the committee and approved
- The outcome of the annual appraisals for the executives, including the Chief Executive, were noted by the committees
- Assurance reports on the capacity and capability of the site leadership teams were provided by the Chief Executive
- The process for appointing and setting the remuneration of two new Managing Directors and a new Chief People and Organisational Development Officer was debated and approved
- The options for applying a cost of living increase to employees on a Very Senior Manager (VSM) contract were debated and a particular option was approved.

The Trust's Remuneration and Nomination Committee also met twice during 2018/19 to:

- Approve a responsibility payment to the Medical Director, Mr Neil Rothnie for his Deputy Managing Director role until this arrangement is reviewed again in March 2020
- Approve an increase in the Managing Director's remuneration to be in line with the other two Trusts.

Tony Le Masurier
Chairman, Remuneration and Nominations Committee

3.2.2 Senior managers' remuneration policy

The Trust's overall pay stance for directors is to pay competitively in comparison with peers in the NHS and in other organisations where this is relevant for specific roles. External comparisons will reflect the size and nature of the Trust.

The remuneration package and conditions of service for executive directors is agreed by the Remuneration and Nominations Committee. In setting the remuneration for executive directors, the committee takes account the following factors:

- Market value of similar posts in similar size organisations
- The benchmarking information provided by NHS Providers
- The pay rates for those staff reporting to the director in question.

The remuneration for executive directors does not include any performance-related bonuses and none of the executives receive personal pension contributions other than their entitlements under the NHS Pension Scheme. With regard to those senior managers who are paid more than £150,000 (which equates to the Prime Minister's ministerial and parliamentary salary), the Committee satisfies itself that this remuneration is reasonable by taking a number of factors into account. These include benchmarking against comparable organisations and taking independent advice from experts in executive remuneration.

3.2.3 Service contracts

Executive directors

The contracts of employment of permanent executive directors contain a maximum notice period of six months. All such contracts are open-ended but are subject to earlier termination for cause or if notice is given under the contract. There is no entitlement to any additional remuneration in the event of early termination for any of the directors. The table below shows the contract start dates for executive directors.

Table 10: Contract start dates for Executive Directors

Name	Job Title	Start Date
James O'Sullivan	Chief Financial Officer/Chief Finance Officer	21 April 2014/1 February 2017
Yvonne Blücher	Chief Nurse/Managing Director	7 October 2015/December 2016
Mary Foulkes	Director of HR and OD/Chief Human Resources Director	12 January 2015/ 1 February 2017 to November 2018

The above executive directors are directly employed by Southend University Hospital Foundation Trust and therefore have a contract of employment with the Trust. The other members of the Joint Executive Group are employed by the other two Trusts (Basildon and Thurrock University Hospitals NHS Foundation Trust and Mid Essex Hospital Services NHS Trust).

Non-Executive Directors

In accordance with the Trust's constitution, the Chairman and the non-executive directors are appointed for a period of office in accordance with the terms and conditions decided by the Council of Governors at a general meeting. Removal from office within the agreed term must be approved by at least three-quarters of all the members of the Council of Governors.

Throughout the year, the Trust held contracts with NEDs as shown below:

Table 11: Non-Executive Directors contracts

Name	Appointment date	Start of current term	End of current term
Alan Tobias OBE	December 2011	December 2014	April 2020
David Parkins	October 2006	May 2016	April 2020
Mike Green	November 2010	November 2016	April 2020
Fred Heddell	December 2011	December 2014	April 2020
Tony Le Masurier	December 2012	December 2015	April 2020
Gail Partridge	December 2016	December 2016	April 2020
Gaby Rydings	May 2016	May 2016	April 2020
Tim Young	December 2012	December 2015	April 2020

In February 2018 and subsequently in September 2018, the Council of Governors agreed to extend the terms of all Non-Executive Directors until April 2020 when it is expected that the three Trusts will merge. This transitional arrangement will be further reviewed in June 2019.

3.2.4 Senior managers' remuneration

Tables 12 and 13 show the senior managers' and non-executive remuneration which set out the payments made during 2018/19.

Table 12: Senior managers and Non-Executive Remuneration 2018/19 *(subject to audit)*

Executive Directors				Year Ended 31 March 2019							
				Salary and fees	Taxable Benefits	Annual Performance related bonus	Long-term performance related bonuses	Benefits In Kind	Other Remuneration	All pensions related benefits	Total
				(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
				£'000	£	£'000	£'000	£	£'000	£'000	£'000
Clare Panniker	Chief Executive		Joint Executive Group	75 - 80	600	-	-	-	-	62.5 - 65.0	**140 - 145**
Tom Abell	Chief Transformation Officer		Joint Executive Group	50 - 55	200	-	-	-	-	85.0 - 87.5	**135 - 140**
Martin Callingham	Chief Information Officer		Joint Executive Group	40 - 45	400	-	-	-	-	-	**40 - 45**
Mary Foulkes OBE	Chief Human Resources Director		Joint Executive Group	25 - 30	-	-	-	-	-	52.5 - 55	**80 - 85**
Paul Kingsmore *	Director of Environment and Infrastructure	from Dec 2017 to Aug 2018	Joint Executive Group	25 - 30	-	-	-	-	-	-	**25 - 30**
John Henry	Director of Environment and Infrastructure	from Sep 2018 to Dec 2018	Joint Executive Group	5 - 10	-	-	-	-	-	12.5 - 15.0	**20 - 25**
Eamon Malone	Director of Environment and Infrastructure	from Dec 2018 - present	Joint Executive Group	10 - 15	-	-	-	-	-	7.5 - 10	**20 - 25**
J. O'Sullivan	Chief Financial Officer		Joint Executive Group	50 - 55	-	-	-	-	-	45.0 - 47.5	**95 - 100**
Danny Hariram	Chief People & Organisational Development Director	from Nov 2018 - present	Joint Executive Group	15 - 20	200	-	-	-	-	-	**15 - 20**
Diane Sarkar	Chief Nurse		Joint Executive Group	45 - 50	-	-	-	-	-	7.5 - 10	**55 - 60**
Jonathan Dunk	Chief Commercial Officer	from May 2018 - present	Joint Executive Group	40 - 45	400	-	-	-	-	172.5 - 175.0	**215 - 220**
Dr Celia Skinner	Chief Medical Officer		Joint Executive Group	60 - 65	-	10 - 15	-	-	-	30 – 32.5	**105 - 110**
Y F Blücher	Managing Director		Joint Executive Group	150 - 155	-	-	-	-	15 - 20	57.5 - 60	**225 - 230**

* The Director of Environment and Infrastructure, Paul Kingsmore, worked in an interim capacity via an agency.

Non-Executive Directors		Salary and fees	Taxable Benefits	Annual Performance related bonus	Long-term performance related bonuses	Benefits In Kind	Other Remuneration	All pensions related benefits	Total
		(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
		£'000	£	£'000	£'000	£	£'000	£'000	£'000
A. Tobias OBE	Chair	45 - 50	-	-	-	-	-	-	**45 - 50**
D. Parkins	Non - Executive Director	15 - 20	-	-	-	-	-	-	**15 - 20**
M Green	Non - Executive Director	15 - 20	-	-	-	-	-	-	**15 - 20**
F. Heddell	Non - Executive Director	15 - 20	-	-	-	-	-	-	**15 - 20**
J. Le Masurier	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**
T. Young	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**
G. Rydings	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**
G. Partridge	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**

All pensions related benefits

Pension Related Benefits relate to the individuals full employment and is not limited to their paid employment with the Trust.

The change in pension related benefits is defined within the Department of Health - Group Accounting Manual 2017-18 as ((20 x PE) +LSE) – ((20 x PB) + LSB), where:

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year
PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and
LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Table 13: Executive Directors DISCLOSURE 2018/2019 *(subject to audit)*

Executive Directors			Year Ended 31 March 2019			
			Total Salary, fees and Bonus	Basildon NHS FT	Mid Essex NHS Trust	Southend NHS FT
			(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)
			£'000	£'000	£'000	£'000
Clare Panniker	Chief Executive	Joint Executive Group	**230 - 235**	75 - 80	75 - 80	75 - 80
Tom Abell	Chief Transformation Officer	Joint Executive Group	**150 - 155**	50 - 55	50 - 55	50 - 55
Martin Callingham	Chief Information Officer	Joint Executive Group	**125 - 130**	40 - 45	40 - 45	40 - 45
Mary Foulkes OBE	Chief Human Resources Director	Joint Executive Group	**75 - 80**	25 - 30	25 - 30	25 - 30
Paul Kingsmore	Director of Environment and Infrastructure (from Dec 2017 to Aug 2018)	Joint Executive Group	**60 - 65**	20 - 25	20 - 25	20 - 25
John Henry	Director of Environment and Infrastructure (from Sep 2018 to Dec 2018)	Joint Executive Group	**25 - 30**	5 – 10	5 - 10	5 - 10
Eamon Malone	Director of Environment and Infrastructure (from Dec 2018 – present)	Joint Executive Group	**40 -45**	10 -15	10 - 15	10 -15
J O'Sullivan	Chief Financial Officer	Joint Executive Group	**160 - 165**	50 - 55	50 - 55	50 - 55
Danny Hariram	Chief People & Organisational Director (from Nov 2018 – present)	Joint Executive Group	**50 - 55**	15 - 20	15 - 20	15 - 20
Diane Sarkar	Chief Nurse	Joint Executive Group	**140 - 145**	45 - 50	45 - 50	45 - 50
Jonathan Dunk	Chief Commercial Officer (from May 2018 – present)	Joint Executive Group	**130 - 135**	40 - 45	40 - 45	40 - 45
Dr Celia Skinner	Chief Medical Officer	Joint Executive Group	**220 - 225**	70 - 75	70 - 75	70 - 75
Y F Blücher	Managing Director	Joint Executive Group	**150 - 155**	-	-	150 - 155

Table 14: Senior managers and Non-Executive Remuneration 2017/18 *(subject to audit)*

Executive Directors				Year Ended 31 March 2018							
				Salary and fees	Taxable Benefits	Annual Performance related bonus	Long-term performance related bonuses	Benefits In Kind	Other Remuneration	All pensions related benefits	Total
				(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
				£'000	£	£'000	£'000	£	£'000	£'000	£'000
Clare Panniker	Chief Executive		Joint Executive Group	75 - 80	600	-	-	-	-	-	**75 - 80**
Tom Abell	Chief Transformation Officer		Joint Executive Group	50 - 55	300	-	-	-	-	-	**50 - 55**
Martin Callingham	Chief Information Officer		Joint Executive Group	40 - 45	1100	-	-	-	-	185 - 187.5	**230 - 235**
Carin Charlton	Director of Environment and Infrastructure	to December 2017	Joint Executive Group	30 - 35	700	-	-	-	-	35.0 - 37.5	**65 - 70**
Mary Foulkes OBE	Chief Human Resources Director		Joint Executive Group	40 - 45	-	-	-	-	-	72.5 - 75.0	**115 - 120**
Paul Kingsmore *	Director of Environment and Infrastructure	from December 2017	Joint Executive Group	20 - 25		-	-	-	-	-	**20 - 25**
J O'Sullivan	Chief Financial Officer		Joint Executive Group	50 - 55	-	-	-	-	-	32.5 - 35.0	**85 - 90**
Diane Sarkar	Chief Nurse		Joint Executive Group	45 - 50	-	-	-	-	-	97.5 - 100	**145 - 150**
Dr Celia Skinner	Chief Medical Officer		Joint Executive Group	60 - 65		-	-	-	10 - 15	220.0 - 222.5	**290 - 295**
Y F Blücher	Managing Director		Joint Executive Group	140 - 145	-	-	-	-	5 - 10	227.5 - 230.0	**380 - 385**

* The Director of Environment and Infrastructure, Paul Kingsmore, is working in an interim capacity via an agency.

Non-Executive Directors		Salary and fees (Bands of £5,000) £'000	Taxable Benefits (To nearest £100) £	Annual Performance related bonus (Bands of £5,000) £'000	Long-term performance related bonuses (Bands of £5,000) £'000	Benefits In Kind (To nearest £100) £	Other Remuneration (Bands of £5,000) £'000	All pensions related benefits (Bands of £2,500) £'000	Total (Bands of £5,000) £'000
A. Tobias OBE	Chair	45 - 50	-	-	-	-	-	-	**45 - 50**
D. Parkins	Non - Executive Director	15 - 20	-	-	-	-	-	-	**15 - 20**
M Green	Non - Executive Director	15 - 20	-	-	-	-	-	-	**15 - 20**
F. Heddell	Non - Executive Director	15 - 20	-	-	-	-	-	-	**15 - 20**
J. Le Masurier	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**
T. Young	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**
G. Rydings	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**
G. Partridge	Non - Executive Director	10 - 15	-	-	-	-	-	-	**10 - 15**

All pensions related benefits

Pension Related Benefits relate to the individuals full employment and is not limited to their paid employment with the Trust.

The change in pension related benefits is defined within the Department of Health - Group Accounting Manual 2017-18 as ((20 x PE) +LSE) – ((20 x PB) + LSB), where

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year
PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and
LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Table 15: Executive Directors DISCLOSURE 2017/2018 *(subject to audit)*

Executive Directors			Year Ended 31 March 2018			
			Total Salary, fees and Bonus	Basildon NHS FT	Mid Essex NHS Trust	Southend NHS FT
			(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)
			£'000	£'000	£'000	£'000
Clare Panniker	Chief Executive	Joint Executive Group	**230 - 235**	75 - 80	75 - 80	75 - 80
Tom Abell	Chief Transformation Officer	Joint Executive Group	**150 - 155**	50 - 55	50 - 55	50 - 55
Martin Callingham	Chief Information Officer	Joint Executive Group	**125 - 130**	40 - 45	40 - 45	40 - 45
Carin Charlton	Director of Environment and Infrastructure	Joint Executive Group	**90 - 95**	30 - 35	30 - 35	30 - 35
Mary Foulkes OBE	Chief Human Resources Director	Joint Executive Group	**120 - 125**	40 - 45	40 - 45	40 - 45
Paul Kingsmore	Director of Environment and Infrastructure	Joint Executive Group	**60 - 65**	20 - 25	20 - 25	20 - 25
J O'Sullivan	Chief Financial Officer	Joint Executive Group	**155 - 160**	50 - 55	50 - 55	50 - 55
Diane Sarkar	Chief Nurse	Joint Executive Group	**140 - 145**	45 - 50	45 - 50	45 - 50
Dr Celia Skinner	Chief Medical Officer	Joint Executive Group	**220 - 225**	70 - 75	70 - 75	70 - 75
Y F Blücher	Managing Director	Joint Executive Group	**140 - 145**	-	-	140 - 145

3.2.5 Pension entitlement for senior managers *(subject to audit)*

The Government's Financial Reporting Manual requires the Foundation Trust to make disclosures regarding the pension entitlements of its directors, as detailed in the following table. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pension benefits for these directors.

Table 16a: Pension entitlement for senior managers 2018/19 *(subject to audit)*

Executive Directors		Year Ended 31 March 2019							
		Real Increase in pension at pension age	Real Increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2018	Employers contribution to stakeholder pension
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clare Panniker	Chief Executive	2.5 - 5.0	5.0 - 7.5	70 - 75	175 - 180	1,393	192	1,160	7
Tom Abell	Chief Transformation Officer	5.0 - 7.5	0.0 - 2.5	20 - 25	0 – 2.5	236	61	149	22
Martin Callingham	Chief Information Officer	0 - 2.5	0	50 - 55	135 - 140	1,085	92	947	18
Mary Foulkes OBE	Chief Human Resources Director	2.5 – 5.0	2.5 – 5.0	15 - 20	30 - 35	321	68	235	11
Paul Kingsmore	Director of Environment and Infrastructure	-	-	-	-	-	-	-	-
John Henry	Director of Environment and Infrastructure	0 - 2.5	0 – 2.5	15 -20	45-50	366	24	263	4
Eamon Malone	Director of Environment and Infrastructure	0 - 2.5	0	0 - 2.5	0	12	5	0	6
J O'Sullivan	Chief Financial Officer	2.5 - 5	0	10 - 15	0	233	49	159	21
Danny Hariram*	Chief People & Organisation Development Director	0	0	0	0	0	0	0	0
Diane Sarkar	Chief Nurse	0 - 2.5	0	45 - 50	110 - 115	907	89	774	21
Jonathan Dunk	Chief Commercial Officer	7.5 - 10	20 - 22.5	30 - 35	65 - 70	458	154	258	19
Dr Celia Skinner	Chief Medical Officer	2.5 - 5	7.5 - 10	85 - 90	260 -265	1,958	208	1,668	32
Y F Blücher	Managing Director	2.5 - 5	7.5 - 10	70 - 75	215 - 220	1,744	203	1,481	15

* No pension figures have been reported for Danny Hariram due to an external administrative error which resulted in contributions not being made towards his pension for approximately 3 years. The Trust is consequently unable to make the required disclosures to comply with the Group Accounting Manual (GAM). Specifically, the 'Pension Related Benefits' and 'Total' columns of the Directors' remuneration 2018/19 table are not complete for Mr Hariram and, similarly, the information included in all the columns of the Pensions table for him in 2018/19 are also incomplete.

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 disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses Government Actuary Department factors in the calculations.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Table 16b: Pension entitlement for senior managers 2017/18 *(subject to audit)*

Executive Directors		Year Ended 31 March 2018							
		Real In-crease in pension at pension age	Real Increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 march 2018	Cash Equiv-alent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equiv-alent Transfer Value at 1 April 2017	Employ-ers con-tribution to stake-holder pension
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clare Panniker	Chief Executive	0.0 - 2.5	-	65 - 70	165 - 170	1,160	25	1,124	27
Tom Abell*	Chief Transformation Officer	-	-	-	-	-	-	-	-
Martin Callingham	Chief Information Officer	7.5 - 10	20.0 - 22.5	50 - 55	135 - 140	945	202	735	18
Carin Charlton	Director of Environment and Infrastructure	0.0 - 2.5	2.5 - 5.0	25 - 30	65 - 70	396	45	329	14
Mary Foulkes OBE	Chief Human Resources Director	2.5 - 5.0	5.0 - 7.5	15 - 20	30 - 35	263	72	189	19
J. O'Sullivan	Chief Financial Officer	2.5 - 5.0	-	10 - 15	-	157	46	110	21
Diane Sarkar	Chief Nurse	5.0 - 7.5	7.5 - 10.0	45 - 50	110 - 115	771	122	643	21
Dr Celia Skinner	Chief Medical Officer	10.0 - 12.5	32.5 - 35.0	80 - 85	245 - 250	1,668	303	1,351	32
Y F Blücher	Managing Director	10.0 - 12.5	32.5 - 35.0	65 - 70	200 - 205	1,481	298	1,171	21

*Tom Abell was a deferred member of the NHS Pension Scheme and therefore no figures were included in the 2017/18 table

3.2.6 Expenses

Table 17: Expenses paid

Directors	2018/19	2018/19	2017/18	2017/18
	Total receiving expenses	Total expenses (£)	Total receiving expenses	Total expenses (£)
Executive Directors	3	3,358	3	2,712
Non-Executive Directors	6	17,480	6	11,988
Governors	2	493	5	518
Total	**11**	**21,331**	**14**	**15,218**

Clare Panniker
Chief Executive
29 May 2019

3.3 Staff Report

3.3.1 Staffing Information

An analysis of the Trust's staff costs and staff breakdown are shown below. Data is presented by staff group and includes details of staff with a permanent employment contract with the Trust and other staff, for example, short term contract staff, and agency/temporary staff.

Also presented is a breakdown at the year end of the number of male and female, directors, other senior managers and employees as well as sickness data for all staff groups for the same period.

Table 18: Analysis of staff costs *(subject to Audit)*

	2018/19			2017/18		
	Total	Permanent	Temporary	Total	Permanent	Temporary
	£000	£000	£000	£000	£000	£000
Salaries and wages	**155,295**	155,295	-	**147,688**	147,688	-
Social security costs	**15,988**	15,988	-	**13,771**	13,771	-
Apprenticeship Levy	**774**	774	-	**693**	693	-
Employer's contributions to NHS pensions	**17,719**	17,719	-	**16,350**	16,350	-
Pension cost - other	**12**	12	-	-	-	-
Other post-employment benefits	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-
Temporary staff - External Bank	-	-	-	-	-	-
Temporary staff - Agency/ Contract	**14,740**	-	14,740	**18,476**	-	18,476
Total gross staff costs	**204,508**	**189,788**	**14,740**	**196,978**	**178,502**	**18,476**
Recoveries in respect of seconded staff to Other NHS bodies	**(801)**	(801)	-	**(1,534)**	(1,534)	-
Total staff costs	**203,727**	**189,788**	**14,740**	**195,444**	**176,968**	**18,476**

Table 19: Number of Staff Employed - by staff group and Role - as at 31 March 2019 *(subject to audit)*

Staff Group	Headcount	FTE
Nursing and midwifery	1314	1144.39
Medical and dental	545	529.59
Additional clinical services	939	793.58
Allied Health Professionals	318	268.92
Professional scientific and technical	143	125.52
Healthcare scientists	106	94.71
Estates and ancillary	243	209.13
Administrative and clerical	998	831.32
Total	**4606**	**3997.16**

Table 20: Number of filled Bank and Agency roles - by staff group - as at 31 March 2019

Staff Group	FTE
Nursing and midwifery	174.16
Medical and dental	44.69
Additional clinical services	170.18
Allied Health Professionals	14.73
Professional scientific and technical	18.14
Healthcare scientists	4.36
Estates and ancillary	61.68
Administrative and clerical	64.21
Grand total	**552.15**

Table 21: Gender Split as at 31 March 2019

	Male	Female
Directors*	7	4
Other senior managers	24	42
Employees	979	3550
Total	**1010**	**3596**

* Directors include the 3 members of the Joint Executive Group (JEG) who were directly employed by the Trust as specified in Table 10 and the 8 Non-Executive Directors (NEDs) as specified in Table 11.

Table 22a: Sickness percentage as at 31 March 2019

Staff Group	% Absence Rate
Nursing and midwifery	3.75%
Medical and dental	1.20%
Additional clinical services	5.67%
Allied Health Professionals	3.05%
Professional scientific and technical	2.21%
Healthcare scientists	1.87%
Estates and ancillary	6.54%
Administrative and clerical	3.72%
Trust total	**3.78%**

Table 22b: Sickness data as at 31 March 2019

Measure	Value
Average full time equivalent(FTE) April 2018 to March 2019	3,926
FTE-days available	1,433,956
FTE-days lost to sickness absence	54,187
Average of 12 months (2017-18 Financial year)	3.78%
Average sick days per FTE (include long term sickness)	14

Source: Based on sickness data from ESR, period covered April 2018-March 2019

3.3.2 Staff policies and actions applied during the financial year

The Trust has an overarching equal opportunities in employment policy which underpins the work the Trust has been doing throughout the year with regards to Equality, Diversity and Inclusion. The strategic aims of Equality, Diversity and Inclusion are monitored and progressed through the Equality, Diversity and Inclusion Committee to ensure the Trust meets not only its statutory duties but also best practice.

Examples of initiatives undertaken in 2018/19 include developing 4 successful diversity network groups – BAME, LGBT+, Disability and Faith. These groups have raised the profile within the Trust and have been a voice at many events and celebrations throughout the year. The groups feed into the Equality, Diversity and Inclusion Committee (EDIC) and are part of the overall agenda. The Trust continues to focus on promoting the other networks to ensure the promotion of inclusion for all groups.

Promotion of the equality and diversity agenda continues as part of the Trust welcome day and representatives from the networks are involved with meeting new starters and promote the groups. We have a rolling diversity calendar of events where we hold celebrations and are part of community events throughout the year. Training is also provided for newly qualified and overseas nurses throughout the year.

The Trust continues to conduct an analysis of the staff survey focusing on the outcomes for Equality and Diversity with agreed interventions put in place to secure improvements. This is reflected in the Equality Diversity and Inclusion overall action plan which incorporates the Workforce Race Equality Standard (WDES), Workforce Disability Standard (WDES) and Equality Delivery System 2 (EDS2).

The Gender Pay Gap report was uploaded to the national database and published on our internet site on 30th March 2019 to meet our statutory requirements. The report demonstrates that both the average and median hourly pay rates are higher for male staff compared to female staff. Similarly, both the average and median bonus payments are higher for male staff compared to female staff with bonus payments in the majority being awarded to male staff (Clinical Excellence Awards). We are committed to taking action to close this gender pay gap and will use the data to enable us to initiate conversations around gender pay issues and to inform actions to address any area of concern.

Table 23: Gender Pay Gap

	Mean Pay Gap %	Median Pay Gap %	Mean Average Bonus Pay Gap %	Median Average Bonus Pay %
Male	21.0946	15.8319	12,505.54	9,040.50
Female	14.8118	12.9720	8,891.80	6,780.37
Pay Gap %	29.7839	18.0644	28.90	25.00

Further to the successful pilot in 2017, the Trust continued to engage the Guardian Service during 2018/19 to support the Freedom to Speak Up agenda. This has led to an increased opportunity for staff to raise concerns confidentially in the workplace and provide a structure for escalation and resolution of concerns. This is supported by the bi-monthly Freedom to Speak up steering group, which is attended by representatives from across the Trust including the 13 nominated speak up Champions from each directorate, which further promotes the agenda.

The Guardian Service attends various staff forums to promote the service and ensure that staff can access. There has been a positive response to the service with staff from various directorates and roles raising concerns. These concerns have either been resolved through coaching by the Guardian or referral to the appropriate manager for informal or more formal intervention.

Since the implementation of our NHSI Retention plan in March 2018 we have seen a general downward trend in voluntary turnover. This has been supported by the introduction of our retire and return scheme (40% return rate), refer a friend scheme, internal transfer scheme for nurses, managers retention tool kit and training sessions, enhanced flexible working options and guidance for manager, building and promotion of the Nurse Alumni Group and the improvement and celebration of staff recognition and long service events. These initiatives have led to an improvement in our 2018 staff survey engagement score.

Sickness has reduced cumulatively from 3.85% in March 2018 to 3.78% at the end of March 2019. This has been supported by our health and wellbeing strategy and continued focus through the health and wellbeing committee. In the last year, we have introduced health and wellbeing champions, mental health first aiders and a musculoskeletal service for employees to receive fast track treatment to prevent and shorten sickness episodes.

The Trust continues to hold a number of accreditations which include its Responsibility Deal Employer pledge and mental health Mindful Employer and the SEQOHS (Safe Effective Quality Occupational Health Service) standard accreditation. The Trust continues to conduct an analysis of the staff survey focusing on the outcomes for disabled staff with agreed interventions put in place to secure improvements. This has been further supported by the Workforce Disability Equality Standard, which will be fully implemented in 2019 in line with the national launch.

Building on the restructuring and amalgamation in 2017/18 the Group People and Organisational Development wide team in 2018/19 continued to support staff reach their full potential through a range of activities that included: continuing professional and personal development opportunities, leadership development, pre-professional education which has enabled a nursing career pathway to be developed allowing an individual to progress from Healthcare Support Worker to Registered Nurse. Opportunities continued to be available in a number of sectors including Administration and Clerical, Leadership and Management presenting the opportunity to offer staff vocational qualifications to improve their career and talent. In addition during 2018/19, opportunities were increased for mandatory and core skills training, simulation and clinical skills training and continued medical education. The foundation for the Respect Programme - a long term multi-disciplinary programme to reduce bullying and harassment was introduced in 2018. This programme draws together multiple pillars of development, support and organisational response to support reduce incidences and promote positive performance management intervention.

With the planned merger of Mid Essex, Southend & Thurrock and Basildon Hospital Trusts, the following policies have been reviewed and new MSB Group policies have been developed. A Joint Policy Development Working Group has been set up which consists of representatives from Staff-Side, Operational Management and Human Resources professionals from across the three Trusts.

- Redeployment procedure
- Flexible Working
- Homeworking
- Disciplinary
- Grievance
- Improving Performance (Capability)
- Sickness Absence
- Appeals
- Job Evaluation/Job Matching
- Relocation

All policies and procedures are subject to an Equality Impact Assessment and a Risk Impact Assessment to ensure that no specific group is adversely affected and there are no inherent risks associated with the policies and procedures.

Communication with employees

Communication through Chief Executive and Executive Group member briefings has sustained communication about the STP and more recently merger plans and corporate services redesign programmes. The monthly emails from the Chief Executive and weekly Managing Director blogs highlight key management and operational messages to staff. The Site Leadership Team members continue to visit wards and departments at least monthly to talk to staff and hear their successes and concerns.

A new cross-Trust bulletin, 1Week, ensures staff across all three sites receives key information, vacancy details and shared success stories consistently and at the same time.

Standard communication channels include regular executive briefings at Core Brief, Friday Round Up, daily Safe@Southend morning safety briefings, The Look magazine and staff emails.

Consultation with employees

In line with the merger plans and service redesign, consultation with corporate services and some clinical services have commenced. This has been supported by the group organisational change policy and redeployment procedure, which has ensured that there is consistency in approach and process across the three sites. This has also been supported by the implementation of a central transformation team to support the consultation process.

The Group Committees which include the Negotiation and Consultation Group and Joint Local Negotiating Committee continue to support joined up working. The Trust's local Negotiating and Consultation Group and the Local Negotiating Committee are the main recognised committees for negotiating and consulting with staff and their representatives. These committees meet regularly to discuss the clinical and corporate reconfiguration and issues affecting the Trust and its performance. Effective partnership working with Staffside continues and they continue to be actively involved in the Equality, Diversity and Inclusion, Speak Up and Health and Wellbeing agenda.

Involvement in performance

The Trust informs staff of its performance on a regular basis, through its communication channels; these include regular executive blogs, Friday Round Up and monthly Core Brief presentations. Staff are encouraged to join in discussions on executive blogs and give feedback on their views regarding performance. Feedback through directorate meetings and daily Safe@Southend meetings is sought. Safe@Southend daily meetings and monthly Core Brief are open to all staff, and form the basis of local team briefings.

Occupational Health and Wellbeing

Following a staff consultation in the autumn 2018 the service has merged with the Occupational Health Services at Mid Essex and Basildon and Thurrock University hospitals; plans are in place to develop a core range of services to all three Trusts and to develop a streamlined approach to health assessments which will eliminate duplication and improve the quality of delivery of the service. All staff continue to have access to the Occupational Health Department.

Staff welcomed the musculoskeletal / Staff Physiotherapy Service which enabled them to be seen without the need for a referral from their General Practitioner (GP), within a considerably reasonable timeframe and on site implying less time was taken off work to attend appointments.

Occupational health continues to work alongside Southend Borough Council in promoting the Trust's health and wellbeing initiatives. Regular NHS Lifestyle health check sessions are offered to staff by ACE Lifestyle.

The Occupational health department featured regularly at Safe at Southend supporting 'Theme of the week' and raising awareness on varied health and wellbeing initiatives and support available to managers and staff.

Counselling support for staff and Confidential Care on other everyday matters continues to be provided by the Trust's Employee Assistance Programme. Staff also have had the opportunity to book onto commissioned stress awareness courses throughout the year.

End of official Influenza reporting via IMMFORM 28th February 2019 saw the Trust's highest recording of Flu uptake with 68% Frontline healthcare workers having received the seasonal flu vaccine. Overall uptake during the year was 66%.

Counter-fraud and bribery arrangements

It is essential that proper use is made of public money and the Trust is committed to high ethical and moral standards. To this end the Trust takes a zero tolerance approach to fraud and corruption with the intention of protecting the property and finances of the NHS and of patients in our care.

The Trust also has procedures in place that reduce the likelihood of bribery occurring which include requirements to adhere to standing orders, standing financial instructions, documented procedures, a system of internal control (including internal and external audit), local counter fraud specialist and a system of risk assessment, and is absolutely committed to maintaining an honest, open and well-intentioned atmosphere so as to best fulfil the objectives of the Trust and of the NHS.

The Trust is also committed to the rigorous investigation of any such allegations and to taking appropriate action against wrong doers, including possible criminal prosecution. To this end the Trust has a number of policies and procedures geared at the elimination of instances of Fraud and Bribery, which include, Disciplinary policy and procedure, Anti-Fraud and Anti-Bribery policy and Raising Concerns at Work (Whistleblowing Policy). The Trust has a local counter fraud HR protocol, commissioned by NHS Protect, which is reviewed and renewed annually.

3.3.3 2018 NHS Staff Survey

The NHS Staff Survey was conducted between 1 October and 30 November 2018. The results from the survey were published on 26 February 2019.

The 2018 response rate results are shown in Table 24.

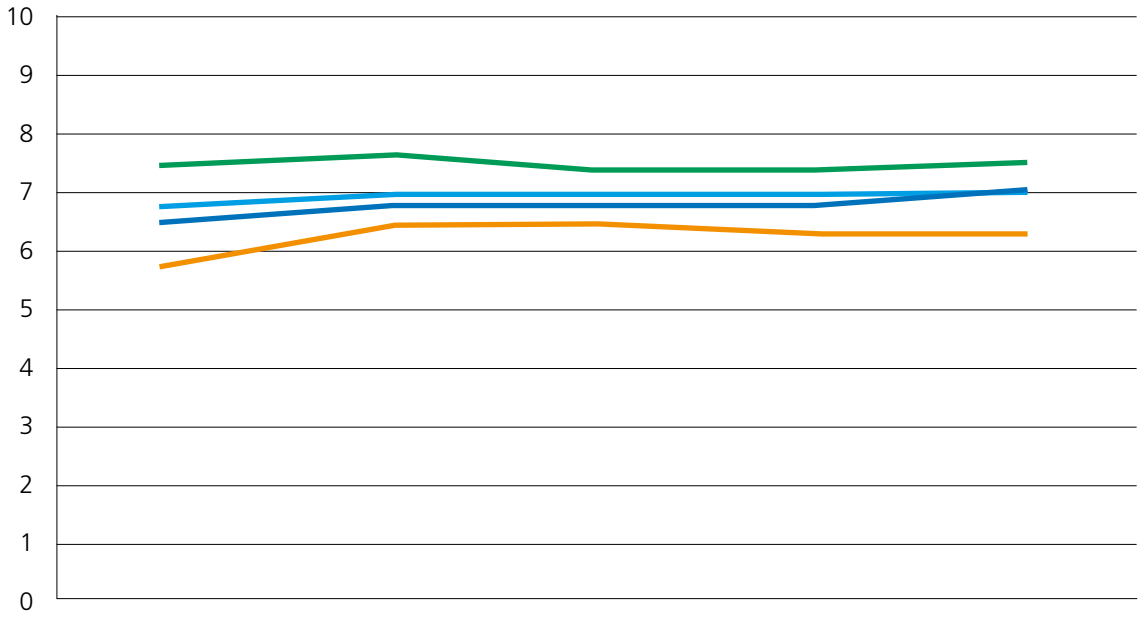
Table 24: Response rate

Response rate				
	2016	2017	2018	2018
	Trust	Trust	Trust	National average
Response rate	41%	41%	49%	44%

Headline Results

- Southend hospital achieved a 49% completion rate for the survey (2149 responses) which is 8 percentage points higher than our result in 2017. The NHS Acute Trust average ("ATA") is 44%.
- The results remained very similar to last year with no statistical changes for Southend.
- Southend Hospital met or exceeded the NHS Acute Trust average score for Quality of Care, Safety Culture, Safe Environment (Violence) and Immediate Managers. Scores for Health & Wellbeing and quality of appraisals continue to remain stable whilst work continues to improve our equality, diversity and inclusion, bullying and harassment and morale scores. Staff engagement scores in Southend Hospital have risen to 6.9, with improvements in all question areas. The NHS Acute Trust Average is 7.0. (See Figure 6 below). The Hospital was rated one of the 'most improved' hospitals in East of England (EOE Survey Resuls, NHS Employers) for staff engagement.

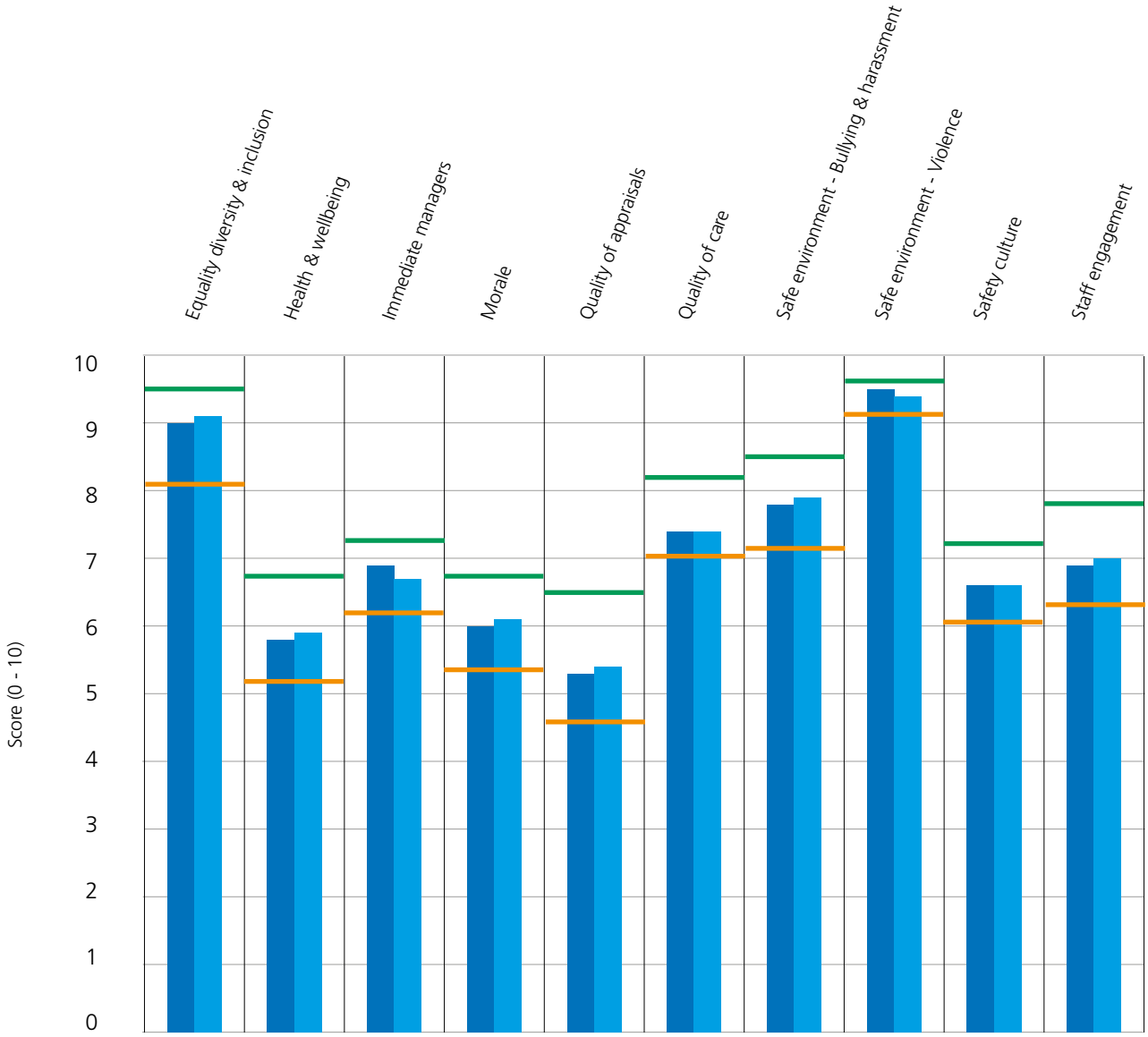
Figure 6: 2018 Staff Survey Results – Staff engagement



	2014	2015	2016	2017	2018
Best	7.5	7.6	7.4	7.4	7.6
Your org	6.5	6.8	6.8	6.8	6.9
Average	6.8	7.0	7.0	7.0	7.0
Worst	5.9	6.4	6.5	6.4	6.4
No. Responses	1,726	1,831	1,707	1,758	2,146

The structure of the NHS Staff Survey has changed and there are no longer key findings, these have been replaced by 10 Themes. The overall scores for these 10 Themes for Southend Hospital are shown in Figure 7 below.

Figure 7: 2018 Staff Survey Results - Overview



Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.0	5.8	6.9	6.0	5.3	7.4	7.8	9.5	6.6	6.9
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. Responses	2,090	2,121	2,127	2,071	1,770	1,906	2,106	2,105	2,102	2,146

The results for each of the 10 themes for the last three years are:

Theme Results	2016	2017	2018	2018
				National average
Equality, Diversity & Inclusion	9.1	9.1	9.0	9.1
Health and Wellbeing	6.0	5.8	5.8	5.9
Immediate Managers	6.8	6.8	6.9	6.7
Morale			6.0	6.1
Quality of Appraisals	5.3	5.3	5.3	5.4
Quality of Care	7.4	7.4	7.4	7.4
Bullying & Harassment	8.0	7.9	7.8	7.9
Violence	9.5	9.5	9.5	9.4
Safety Culture	6.6	6.5	6.6	6.6
Staff Engagement	6.8	6.8	6.9	7.0

3.3.4 Future priorities and targets

A Staff Survey Action Plan has been developed to address the key issues. This plan has and will inform current and future change programmes and actions within the Trust. There are 6 areas of concern:

- Improving communication
- Dignity and respect
- Staffing levels (attract and recruit)
- Leadership and management development
- Staff health and well-being
- Staff retention, recognition and engagement

The Staff Survey Action Plan forms the basis of the directorate action plans which will ensure the appropriate focus, resource and support can be given to these and that these translate into visible changes that make a difference to staff and patient care.

Each directorate will be accountable for the development and delivery of their action plans. Directorates will also take actions forward any significant areas of concern i.e. where there are adverse variations in scores against ATA's unique to that area. Directorate Action Plans now also have MSB/Trust action sections to align to Group goals.

Communication

A key aim of this action plan is to develop an open, honest and transparent relationship between staff and leadership by:

- The publication of our Staff Survey Action Plan including dates and action owners.
- Engaging with our workforce via a Staff Survey Implementation and communication plan. The plan includes engagement events. These events provide staff with the opportunity to review the plans to improve in each of the 6 areas, comment, provide feedback and submit ideas and suggestions on alternative or additional actions we can take.
- Implementing a Task & Finish group to work with the staff survey and site lead, our Union representatives and staff to ensure the commitment to 'you said we did' is fulfilled.
- Developing a Staff Survey group brand aligned to the NHS Staff Survey branding
- Creation of a Staff Survey intranet hub providing access to Staff Survey results, the published action plan, VLOG and BLOG updates, dates for engagement events, progress so far and good news stories.
- Promotion of and utilisation of a central email address 'yousaidwedid@' to encourage staff feedback and participation

Monitoring of progress

- Monitoring of progress of our Action Plan via site PRM, Site Leadership team and with oversight by the Workforce Committee. Accountability at Directorate level for delivery via regular monitoring of Directorate plans by HR Business Partners, reporting to the Site Leadership team.

Planning for 2019 NHS Staff Survey

- Development of a solid campaign for the 2019 Staff Survey aimed at securing a 60% response rate.
- KPI targets will be set for 2019 Staff Survey aiming to meet or exceed the NHS ATA in the themes which are below the ATA.

The Trade Union (Facility Time Publication Requirements)

Table 25: Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
23	3919.27

Table 26: Percentage of time spent on facility time

Percentage of time	*Number of employees*
0%	22
1-50%	-
51%-99%	-
100%	1

Table 27: Percentage of pay bill spent on facility time

First Column	*Figures*
Provide the total cost of facility time	£18,402.37
Provide the total pay bill	£196,628,238
Provide the percentage of the total pay bill spent on facility time, calculated as:	0.009359
(total cost of facility time ÷ total pay bill) x 100	

Table 28: Paid TU activities

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	100%

3.3.5 Expenditure on consultancy

The total expenditure on consultancy for the financial year is £1.1m (2017/18 £1.3m). Consultancy costs have reduced, however, the on-going transformation and efficiency initiatives undertaken by the Trust have required specialist consultancy support during the year.

3.3.6 Off payroll arrangements

The Trust adheres to the regulatory requirements in this area and makes regular submissions to NHSI on the use of off-payroll arrangements. The Trust will continue to review these recommendations regularly.

Table 29: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	-
No. that have existed for between two and three years at time of reporting.	-
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

Any off-payroll engagements are subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 30: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which...	
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

Table 31: For any off-payroll engagement of Board members, and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	13

3.3.7 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 median remuneration of the organisation's workforcee.

Table 32: Highest and median remuneration

	2018/19 £000s	2017/18 £000s
Band of Highest Paid Directors Total Remuneration	165 - 170	150 - 155
Median Total Remuneration	26	26
Ratio	**6.5**	**6.0**

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. The median remuneration of all employees is based on employees with a permanent contract with the Trust as at 31 March 2019, part time staff are adjusted up to the equivalent full time earnings. The banded remuneration of the highest paid director is also calculated as at 31 March 2019.

As there has been a sharing arrangement for all of the Executive Directors with only one third of their annualised remuneration being taken into account in the Fair Pay calculation (with the exception of the site Managing Director), the Managing Director remains the individual the calculation is based on.

3.3.8 Exit Packages 2018-2019 *(subject to audit)*

There was no exit package during 2018/19 (1 in 2017/18).

Table 33: Exit package costs

Exit package cost band	2018/19			2017/18
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total number of exit packages
	Number	Number	Number	Number
<£10,000	-	-	-	-
£10,001 - £25,000	-	-	-	-
£25,001 - 50,000	-	-	-	-
£50,001 - £100,000	-	-	-	-
£100,001 - £150,000	-	-	-	1
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exit packages by type	-	**-**	**-**	1
Total resource cost (£)	-	-	-	£160,000

3.4 Disclosures set out in the NHS Foundation Trust Code of Governance

Southend University Hospital 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 of Directors seeks to comply with the NHS Foundation Trust Code of Governance and has established processes to enable it to comply with the code provisions. The Board reviewed its compliance against the revised Code in 2018/19 and agreed that the Trust complied with all of the main and supporting provisions of the Code, where they were applicable.

All disclosures required by the Board of Directors and its committees can be found in the Directors' Report in Section 3.1.

All disclosures required by the Council of Governors about its activities can be found in the Council of Governors Report in Section 3.1.11.

All disclosures required in relation to remuneration can be found in the Directors' Remuneration Report Section 3.2.

3.5 NHS Improvement's Single Oversight Framework

NHS Improvement's (NHSI) Single 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 (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

Southend University Hospital NHS Foundation Trust has moved into Segment 2 during 2018/19 as compared to Segment 3 in 2017/18 due to the compliance certificate in respect of the Governance breaches. More information is provided in the Annual Governance Statement Section 3.7. The description of trusts that fall into Segment 2 is set out in the Single Oversight Framework as follows:

> 'Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.'

This segmentation is the Trust's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHSI website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Table 34: Overall finance score

Area	Metric	2018/19 Scores				2017/18 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	3	4	4	4	4	4	4	4
	Liquidity	4	3	2	3	3	3	4	3
Financial efficiency	I&E margin	4	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	1	2	1	1	1	1	1	1
	Agency spend	4	4	4	4	4	4	3	3
Overall scoring		3	3	3	3	3	3	3	3

3.6 Statement of the Chief Executive's responsibilities as the accounting officer of Southend University Hospital NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation 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 Southend University Hospital 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 Southend University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care 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 and
- prepare the financial statements on a going concern basis.

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/her 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 NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Clare Panniker
Chief Executive
29 May 2019

3.7 Annual Governance Statement

3.7.1 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.

3.7.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Southend University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Southend University Hospital NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3.7.3 Collaborative Governance Arrangements

Whilst Southend University Hospital NHS Foundation Trust remains a statutory organisation governed by a Board of Directors holding the fiduciary duties required by legislation and the Trust Constitution, a collaborative governance framework (with a contractual joint venture overlay) was and continued to be in place between the three acute trusts (Basildon and Thurrock University Hospitals NHS Foundation Trust, Southend University Hospital NHS Foundation Trust and Mid Essex Hospital NHS Trust) within the Mid and South Essex Sustainability and Transformation Partnership (STP). Under this arrangement, in December 2016 the Boards of Directors of each trust delegated those functions that could be safely delegated within the parameters of law and good corporate governance, to a Joint Working Board (JWB) comprising a committee of each Trust meeting in common on a monthly basis. The aim of this collaborative governance was to deliver joined up clinical service planning across the three trusts.

In December 2018 and January 2019, the three trusts decided to take a key next step towards integrating their corporate governance arrangements. They decided that from February 2019, the Trust Boards would meet only in common, save for exceptional circumstances and a single meeting per year to approve the respective trust's annual report and accounts. The Trust Board meetings in common occur on a monthly basis.

The Trust Boards also decided that their finance and performance committees and their quality and patient safety committees would meet only in common under harmonised terms of reference. The Trust Boards also created a new workforce committee in common. Recognising the strategic importance of workforce, this committee provide additional capacity and capability to co-ordinate a strategic approach to workforce.

As such, the capacity to identify and handle strategic and high level operational risks and to put in place effective controls across the three trusts has developed to complement the systems within the individual organisations and hospital sites. The key aspects of the risk and control framework across the "Group" are drawn out in the relevant sections of this Annual Governance Statement.

Further details about the collaborative governance arrangements can be found in the Director's Report (section 3.1).

3.7.4 Capacity to handle risk

The Board of Directors holds ultimate responsibility for ensuring that the Trust delivers upon its statutory duties and governance requirements. As such, the Board of Directors has the authority and responsibility for the establishment, maintenance, support and evaluation of the Trust's Risk Management Strategy.

The JWB, the finance and performance, quality, and workforce committees in common provide additional capacity to handle risk across Southend University Hospital NHS Foundation Trust and our partner trusts in Mid and South Essex (Mid Essex Hospital NHS Trust and Basildon and Thurrock University Hospitals NHS Foundation Trust) as explained in the "risk and control framework" section below. Hereafter the aforementioned organisations will be referred to collectively as "the three trusts" or "the Group". Any reference to "the trust" refers specifically to Southend University Hospital NHS Foundation Trust.

The Oversight Committee provides specific capacity to assess and manage the risks and governance challenges associated with the collaborative governance framework under which the three trusts are operating. Further details on the Oversight Committee and its review of the effectiveness of the collaborative governance framework can be found in the Directors' Report (section 3.1).

The Future Organisational Form (FOF) Programme Board provides dedicated capacity to identify and handle risks associated with the proposed merger of the three trusts. The FOF Programme Board comprises executive directors (including me as Chief Executive), the Chairs of each trust and a number of non-executive directors to provide the appropriate level of scrutiny and oversight of the risks associated with a change in organisational form. This Programme Board will continue to meet throughout 2019/20 and into the first year of the new organisation to provide additional assurance on the strategic and operational risks associated with the transition.

Leadership on risk management is provided by the Board of Directors, through me, as Chief Executive, site and divisional directors. Clinical and corporate directors are accountable for risk management within their own directorates and divisions. The executive lead for risk management for the entirety of the 2018/19 year was the Chief Nursing Officer, who also holds executive responsibility for risk management across the Group. As such, the Chief Nursing Officer provides additional capacity to identify risks that relate to the strategic objectives of the wider mid and South Essex STP and to put in place system-wide as well as local controls to mitigate those risks. The operational site lead for risk management is the Director of Nursing.

The roles and functions of the executive directors are formally reviewed each year to ensure that there are no gaps or overlays in the corporate management structure of the Trust. During 2018/19 this review has also taken account of any gaps or overlaps in the functions of the joint executives and their interface with the site leadership teams and cross-site services.

As the joint working between redesign of clinical support, corporate support and clinical services across the Group has developed, a number of group-wide leadership roles below executive level were created in order to provide additional capacity to handle risk in critical and high-risk services. These roles include a Group Head of Information Governance, a Group Director of Procurement and a Group Chief Pharmacist. The creation of these posts provides a single point of leadership for these services and mitigates the risk of the control framework across the three trusts becoming ineffective as the organisations develop towards the proposed merger.

The role of each director is clarified through the agreement of comprehensive job descriptions. Key priorities are determined by and aligned to the objectives documented in the Annual Plan. Training needs are identified and met through personal development plans. Performance against objectives is assessed throughout the year. Formal appraisals are undertaken of the joint executives by me as chief executive. My formal appraisal is undertaken by the Chairs of the three trusts. The outcomes of these appraisals are presented to the Remuneration and Nomination Committees of the three trusts meeting in common. The structure of the executive and site leadership teams ensure that appropriate focus is placed on managing the key risks faced by the trust and sound management of its financial, human and property resources within a framework of good governance.

Operational day-to-day management of the trust is delegated to the respective site leadership team in partnership with the directorate clinical directors. The Site Leadership Team meets on a weekly basis and the Corporate Management Team comprising the site leadership team and the triumvirates (Clinical Directors, Associate Directors and Heads of Nursing) meet on a monthly basis.

Each directorate's clinical director is a practising clinician and is supported professionally and managerially by a directorate associate director and a directorate head of nursing/ head of professions. The Site Leadership Team implements the strategies and decisions of the Board of Directors and has responsibility for operational decision-making and the management of operational risks. All clinical directorates are sub-divided into specialist services which are led by a practising clinical specialist, a service unit manager and have a designated matron. This triumvirate has delegated responsibility for the professional and managerial performance of the specialist service, reporting to the directorate clinical director and the directorate general manager.

Risk specialists and advisors are engaged where appropriate throughout the trust and each maintains the relevant qualifications and experience that competent advice is available to all managers. Professionals in patient safety, medicines management, fire safety, security, health and safety, clinical risk, law, business continuity and emergency planning, operational and patient flow improvement, and organisational change are available to support directorates. Together with clinical and non-clinical leads and advisors, these specialists support the creation, implementation and monitoring of policies, protocols and guidelines for the effective control of risk. All employees have an important role to play in identifying, assessing and managing risk. To support employees in this role, the trust provides a range of policies, strategy, procedures, protocols and guidelines, together with information at all levels that are relevant to an individual's role. The trust aims to ensure that employees have the knowledge, skills, support and access to the expert advice necessary to manage risk efficiently and effectively. Support and training are provided in line with the risk management training needs analysis, which identified the level of training appropriate for an individual's authority and duties. The trust has a clear policy for staff completion of mandatory and core training aimed at managing risk. The policy is clear that managers are responsible for ensuring staff completion of training. This is monitored regularly and reported as part of the workforce section of the monthly integrated performance report to the Site Leadership Team, the Site Governance Forum and the three Trusts Boards in Common.

Learning from good practice is encouraged, as is learning from mistakes in order to continually strive for better outcomes for patients. Learning is shared internally through team, professional and directorate meetings where clinical practice changes following incidents and complaints are discussed and corporate meetings where risk recommendations from solicitors following inquests or claims are shared. The trust has a high rate of incident reporting when benchmarked against peer organisations. This is considered by the board and its committees as a reflection of an open and transparent culture across the organisation.

In addition, during 2018/19 the trust has maintained a number of communication methods which have proven effective and popular with staff. These include:

- The weekday 'Safe@Southend' patient safety meeting, led by a member of the site leadership team;
- Safety messages displayed on computer screens and on the trust intranet;
- Directorate patient safety briefings;
- Weekly email from the Managing Director;
- Regular attendance by the Risk & Patient Safety Team at Directorate Governance meetings

As the 2018/19 year progressed, these communication methods were harmonised across the Group, with a balance of group-wide and site-specific content.

Learning is shared externally by reporting to organisations such as the Care Quality Commission (CQC), the National Reporting and Learning System (NRLS), the Medical and Healthcare Products Regulatory Agency (MHRA), the NHS Counter Fraud Authority, the local commissioners and the Area Team of NHS England.

The three trusts have established a Risk and CQC Compliance Group which co-ordinates the identification, dissemination and implementation of learning from incidents and developments in best practice across all sites. This group, comprising risk, compliance, corporate and clinical governance leads, provides additional capacity to handle risk in a co-ordinated way across all three trusts. The role and mode of working of this group continued to evolve during 2018/19.

3.7.5 The risk and control framework

The Risk Management Strategy is one of the seven designated policies that must be agreed and endorsed by the Board of Directors. It details the trust's approach to risk management and describes it as both a statutory requirement and a key element of good management. Risk management is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the trust's ability to discharge its functions as a partner in the local health and care system, as a public benefit corporation and a provider of health services, as a custodian of public funds and a significant employer. The Risk Management Strategy clearly sets out accountabilities for risk management at each level in the organisation and aims to ensure a comprehensive system of internal control without stifling flexibility and innovation.

The strategy and its associated policies and procedures set out the processes for identifying, assessing, communicating, and documenting, escalating, managing and reviewing risks. The effectiveness of the Risk Management Strategy and its implementation is monitored by the Audit Committee. In doing so, the Committee mitigates the risk of failure to comply with the Foundation Trust Licence condition 4 (governance).

Risks are identified in a number of ways, including recommendations from external inspection reports, organisational failures and incidents, and more local methods of risk profiling, incidents, claims, complaints, receipt of alerts and risk assessment of work-related activities. Risks are assessed using an agreed risk assessment template and recorded on the Corporate Risk Register, which is a single repository for all the risks identified across the trust.

Each division is responsible for managing a risk register which is reviewed by senior managers and risk leads on a regular basis. The Site Governance Forum which comprises our Non-Executive Directors and Site leads reviews the site Board Assurance Framework on a monthly basis. The Boards in common receives the group Board Assurance Framework (BAF), capturing those risks which could impact upon the delivery of the strategic objectives of one or more of the trusts, or of the STP as a whole, on a monthly basis. The BAF ensures that the Board of Directors is aware of the highest risks to the achievement of the trust's objectives and the controls necessary to ensure that these risks are maintained at an acceptable level. A group-wide corporate risk register and issues log were also developed to record and manage high level operational risks and emerging issues. The appetite for risk is determined for individual circumstances or events and the Board will request additional controls where it wishes to further reduce the likelihood or impact.

The Finance and Performance, the Quality, and Workforce committees in common regularly review relevant significant risks and incidents relating to their areas of responsibility. The Audit Committee independently monitors, reviews and reports to the Board of Directors on the extent to which the trust has in place an effective system of governance, risk management and internal control. The Audit Committee has a key role in assuring the trust of the validity of its Annual Governance Statement. This is achieved by regular review of the system of internal control and reports from auditors throughout the year and at least two examinations of the draft Annual Governance Statement prior to its submission to the Board of Directors for adoption.

The Council of Governors is the principal mechanism by which the trust involves patients and the public in managing risks which impact upon them. Governors are encouraged to highlight risks, in particular those relating to quality, patient safety and patient experience at the Council of Governors and the Patient and Carer Experience Group. Executive and site directors regularly provide assurance at these meetings on how risks are being managed. The trust also involves governors in board walkabouts and audits to help identify risks in the patient environment.

During 2018/19, the Oversight Committee agreed to consider an additional element of the risk and control framework across the three trusts providing assurance to the JWB, supplementing the scrutiny to the system of internal control provided by the individual trust audit committees, which continue to meet on a quarterly basis.

The most highly rated risks recorded on the Group BAF during 2018/19 were:

- Failure to provide an environment conducive for colleagues to design, adopt and implement innovative practices.
- Failure to implement the merger of three trusts into one trust leading to sub-optimal decision making
- Failure to enable and empower leaders in all areas of the organisation to create a culture of continuous improvement
- Failure to deliver improvement of national performance targets in the agreed trajectories
- Failure to deliver clinical service change / reconfiguration to meet the needs of the local population currently and in the future, against agreed timescales.
- Failure to gain agreement and consensus of local communities to changes that reflect best practice
- Failure to be the demonstrable employer of choice for people with the right values, behaviours, skills and experience.
- Failure to lead and develop colleagues to ensure they demonstrate support, engagement and high levels of performance in order to drive improvement
- Failure to deliver the financial plan
- Failure to develop and fund a long term capital plan which addresses the clinical, estates and technology needs of the organisation
- Failure to deliver transformation in corporate support to create a fit for purpose future proofed structure

- Failure to achieve and deliver on long term financial sustainability and effective use of resources
- Failure to consistently deliver safe, responsive and efficient patient care in a cost effective manner because the current estate and infrastructure is not fit for purpose

The principal risks for the Trust during the year and in the immediate future are:

- Recruitment and retention of sufficient highly skilled staff with specific experience.
- Delivery of the three key national performance targets.
- Being able to meet the financial target set by NHS Improvement, in an environment where core services are underfunded, money available to NHS organisations is reduced, and the cost of delivering specialised services is high.

These risks are broken down into a number of component parts covering the different drivers of these risks, and appropriate mitigating actions for each component identified.

Risk	Explanation	Mitigating actions implemented and underway
Recruitment and retention of sufficient highly skilled staff with specific experience	The ability to recruit and retain appropriate trained staff remains a key organisational risk that may impact on patient safety, patient experience and operational activity.	Recruitment trajectory continues to be monitored against the vacancy rates. Nurse staffing levels and skill mix are reviewed on a daily basis and adjusted according to patient acuity and dependency to provide safe care. Staffing numbers are discussed daily at 'Safer Southend' and at each of the capacity meetings held throughout the day. There have been a number of successes in converting agency medical workforce to the local medical bank. A robust approval process for agency staff across all disciplines remains in place. Engagement of agency medical staff above NHSI's capped rate will not take place unless expressly approved by an executive director, and only on the grounds of patient safety.

Risk	Explanation	Mitigating actions implemented and underway
Delivery of the three key national performance targets	The risk of poor patient experience associated with A&E waiting times remains high. Longer than desired waits are informed due to a combination of factors including increasing A&E attendances which are 3.54% higher than in the previous year, higher than national average conversion to admission rates and late in the day discharges resulting in acute beds not being readily available at the time of greatest demand. Performance against the 62-day referral to treatment target for cancer patients has been impacted by increased numbers of referrals. Performance against 18-week referral to treatment (RTT) target has been challenging.	With the introduction of Teletracking in the Autumn of 2018, the Trust now has greater visibility of bed availability as well as pending and confirmed discharges. This improved visibility means that beds once vacated and cleaned can be allocated at pace. Performance against a number of TeleTracking KPIs is monitored daily and additional support directed to those wards that have the greatest challenge. Focus has been on reducing the numbers of patients waiting over 104 and 62 days, to ensure sustainable delivery of the target. Focus on meeting the increasing demand for non-elective activity and cancer has reduced capacity for RTT. On 31st March 2019 when we ran the PTL no patients had waits of over 52 weeks. However through our regular validation of pathways 2 patients were subsequently identified as having had incorrect clock stops and as a result should be shown as waiting over 52 weeks on 31 March 2019.
Failure to continue to be financially sustainable	A reduction in funding and/or Increasing costs, or growth above the amount funded within the minimum income contract will threaten the ability of the Trust to deliver its control total.	Robust financial governance including regular performance reviews to ensure budgets are delivered and corrective action is taken where they are not. Strengthening of CIP governance processes and development of a change management office across the Group to support the Trust in identifying and delivering productivity and efficiency schemes. Monthly monitoring of capital expenditure. Working with commissioners to develop demand management schemes.

Quality governance

The Trust quality and performance framework is in place to ensure that quality is at the centre of the services we provide and supports the Trust vision of providing high quality care for every patient, every time. There are numerous systems and processes in place to ensure that quality is measured, monitored and appropriate action taken to improve quality.

Identifying and measuring quality

The Trust uses a variety of methods to identify and measure quality and safety issues.

A whole hospital meeting (Safe@Southend) takes place every weekday facilitated by a member of the Site Leadership Team to highlight quality and safety issues and agree immediate actions to resolve the issue. The meeting also focuses on a key quality topic each week and brings together shared learning and lessons from across the organisation.

The Trust has a Freedom to Speak Up Service in place enabling staff to raise their concerns using a variety of means including the independent Guardian Service. Where necessary, the guardian will escalate issues anonymously using a red, amber and green flagging system and any red related issues such as patient safety, staff safety, safeguarding and care are responded to within 12 hours.

The Trust has a good incident reporting culture in place and over the last few years the number of low harm incidents has increased which indicates a positive safety culture. Information from the National Reporting and Learning Service shows that on average, 98% of all patient safety incidents report no or low harm.

Numerous external reviews have taken place of our services during 2018/19 and we are keen to learn from these reviews and put measures in place to address any quality issues. The reviews usually focus around a specific service or function but are occasionally Trust wide such as those carried out by our commissioners. Learning is shared via the Quality and Safety Committee to ensure that appropriate action is taken where required to improve quality.

Monitoring quality

Systems are in place to monitor quality performance, ensuring that where poor performance is identified, action can be taken as appropriate. The Integrated Governance Framework (Integrated Quality and Performance Board Report (IQPBR)) allows board to ward scrutiny of quality and safety metrics and contains relevant internal and external benchmarking. The IQPBR is reviewed and monitored by the trust board and the Quality and Safety Committee which focuses specifically on a number of patient safety quality metrics such as falls, pressure ulcers and hospital acquired venous thromboembolism.

The Quality Committee is responsible for providing assurance to the Trust board that the quality agenda is being embedded in line with the quality strategy and that performance is measured and monitored. The Quality Committee escalates any quality or safety concerns to the Southend Hospital Governance Forum.

Performance review meetings are held with each Directorate to review quality, safety, governance, finance and human resources metrics. These check and challenge meetings enable the Trust senior managers to identify any potential quality issues. Deep dives are carried out where themes of concern or good practice are identified.

Quality indicators are also reviewed on a monthly basis by the commissioners as part of the Clinical Quality Review meetings where data and information is triangulated to identify potential quality or safety issues in addition to sharing good practice.

Areas for quality improvement are identified as part of the annual planning process and link with the clinical audit and quality improvement plans at both corporate and directorate level. Internal and external intelligence is used on which to base these plans including risks, clinical outcomes, regulatory compliance, national clinical audit outcomes and patient experience. There are a number of different quality improvement programmes that individuals and teams participate in.

Quality impact assessments are undertaken as part of the development and proposal stage of developing business plans or changes to service. The assessments involve considering the impact that these changes may have on patient safety, patient experience or clinical effectiveness and they are reviewed during the implementation phase of any project to identify and address potential issues.

Patient care

The patient engagement strategy was introduced in July 2016 with the aim to improve patient engagement at both an individual care level and in terms of the trust's service design and development. The strategy set out a comprehensive implementation plan which is now complete. We continue to work in line with the principles and objectives set out in the strategy, and our Patient and Carer Service Improvement Focus group has met regularly over the past year to discuss development plans proposed by the trust. The group has been involved with a number of projects including the trust's ophthalmology transformation project; the development of patient information leaflets; patient surveys; and our new bereavement support services. The Friends and Family Test ('FFT') is administered by the Patient Experience Team ('PET') and monthly reports are produced for each directorate to highlight areas with excellent performance, and areas where improvements are needed. A central log is kept to record the service improvements made as a result of feedback received from service users and this learning is shared both at the time of implementation, and within the monthly reports for all directorates.

Over the past year the PET have re-launched the compliments process for the trust and made improvements to the way in which these are acknowledged and reported. The PET now follows a formal process to write to each person making the compliment and to thank them for taking the time to do so. The PET have also introduced a central database for compliments held in the same area as the FFT data so that this can be analysed together to provide an overview of positive and negative comments in each area.

We know that staff experience directly links to our patient's experience, and this year the PET team have implemented a new feedback scheme for staff called 'Above and Beyond'. Staff are encouraged to nominate their colleagues who they feel have gone above and beyond their usual duties to improve patient experience. This scheme has been very well received by staff and we anticipate in time that this will contribute towards a positive patient experience.

The Trust continues to receive a consistent level of complaints regarding service provision, care and patient experience. The number of complaints as compared with hospital attendances remains below 1%. During 2018/2019 the Trust continued to reduce the backlog of complaints carried over from the previous financial year and the quality and efficiency of the Central Complaints Team (CCT) has vastly improved. Response times within the Directorates have improved in many areas; two areas have faced challenges in terms of staffing and management of complaints which has impacted on performance. The CCT have provided support to these areas to improve response times which has been effective. A robust plan is in place to improve the governance arrangements in these areas which we are confident will improve the quality and responsiveness to complaints.

We have recently launched the new 'complaints satisfaction survey' to collect feedback on the trust's complaints service. At the point of acknowledging a new complaint, the CCT ask complainants to 'opt in' to the survey, and at the conclusion of their complaint they are sent a survey by an independent survey provider. We expect to receive the first results of the survey in quarter one of 2019/2020.

Compliance with CQC registration standards

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

The Trust has a programme in place to deliver the vision of moving from a 'requires improvement' CQC rating to 'good'. This is supported through the Maintaining High Standards group that meets weekly to address areas of non-compliance identified through internal or external and/or regulatory compliance reviews and ensures action is taken accordingly. A programme of mock inspections takes place in the clinical areas against the CQC key lines of enquiry. The purpose of the inspections is to foster a culture of continuous improvement, enabling key issues and themes to be identified and to ensure good practice is shared across the organisation for learning and improvement. During 2018/19, the Trust carried out 19 reviews across its clinical services including both inpatient and outpatient services and an out of hours review.

The Trust is registered with the CQC to carry out the following legally regulated services: maternity and midwifery services, termination of pregnancies, family planning services, treatment of disease, disorder or injury, assessment or medical treatment for persons detained under the 1983 act, surgical procedures, diagnostic and screening procedures and management and supply of blood and blood derived products.

The latest CQC findings and actions the trust is taking in response to the findings are detailed within the Quality Report (section 4). The CQC improvement plan includes the CQC MUST take and SHOULD take actions and is monitored and updated fortnightly and includes re-visiting closed actions to gain assurance that improvement has been sustained. The improvement plan is presented at the Maintaining High Standards meeting for action and at the Site Leadership Team meetings and the Quality Committee to provide assurance that actions are being progressed and improvement demonstrated.

Workforce strategies and safer staffing systems

The ability to attract, retain and develop a diverse, high calibre, highly engaged, high-performing workforce is key to the Trust in meeting its vision of providing 'high quality care for every patient every time'. The Trust is at risk of being unable to maintain the right workforce capability and capacity to deliver its strategic plan, due to workforce shortfalls and challenges in recruiting and retaining staff in several staff groups. Recruitment and retention of registered nurses continues to be a challenge in the Trust and in the locality. The Trust has put in place controls and action plans to mitigate these risks and these are described in the Organisational Risk Register. We are working towards compliance with the Workforce Safeguards recommendations. Nursing establishment and skill mix requirements are reviewed in accordance with NICE guidance and presented to the Trust Board. A monthly assurance paper is provided to the trust board to report ward nurse staffing levels in relation to patient acuity and dependency and care need; and includes correlation with key quality and safety indicators. A robust process is in place to provide senior professional nursing oversight of nursing and midwifery staffing levels on a day to day basis to ensure mitigation plans are enacted to maintain safe care.

We are working in partnership with Basildon and Thurrock Hospital and Mid Essex Hospital in the implementation of a comprehensive nursing and midwifery retention plan; and plan to deliver a suite of nursing and midwifery recruitment activities across the three hospitals in the next 12 months. We will continue to deliver career development pathways through apprenticeship to Registered Nurse and to optimise our successful OSCE support programme for overseas nursing recruits.

Register of Interest

The foundation trust has published on its website an up-to-date register of interests for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance.

Compliance with NHS FT Provider Licence condition 4 – governance arrangements

The Board of Directors is pleased to announce that in August 2018, NHS Improvement (NHSI) removed the additional licence condition imposed by them. The reasons for NHSI's decision were:

- The Trust has improved its governance following the independent review undertaken by Deloitte in 2014 and
- The most recent Care Quality Commission (CQC) inspection report published in April 2018 rated the Trust as 'good' for the well led domain.

Other regulations

Pensions

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 organisation's obligations under equality, diversity and human rights legislation are complied with.

Environmental carbon reduction

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

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

The Trust has an annual plan and an agreed financial control total which is approved by the Board of Directors and submitted to NHSI. Performance against the plan is monitored by the Assurance Committees and the Board of Directors. NHSI together with representatives from the Board discuss the Trust's monthly performance and anticipated full year forecast and any deviation from the agreed Control Total.

The monthly Integrated Performance Report is produced which contains performance indicators to monitor the metrics for performance, quality and workforce information.

The Trust's resources are managed within the Corporate Governance Framework, which includes Standing Financial Instructions and a Scheme of Delegation. Assurance regarding the financial governance arrangements is supported by internal and external audit, which critically assess the economic, efficient and effective use of resources and report directly to the Audit Committee.

Directorate and corporate departments are responsible for the delivery of financial and other performance targets via a performance management framework incorporating service reviews with the Site Leadership Team for key areas and compliance with the Trust's Accountability Framework.

The Trust is part of the mid and south Essex Sustainability and Transformation Partnership (STP) and is working as part of the three Trusts to reconfigure services. A Joint Executive Group has been appointed to oversee and deliver the strategy of improved patient services across the Mid and South Essex region.

3.7.7 Information governance

NHS Digital (formerly the Health and Social Care Information Centre) has published guidance and a checklist for reporting information governance (IG) incidents. This checklist comprises a baseline scale dependent on the level of individual involvement (ranked from 0 to 3). Together with a sensitivity factor, it provides an overall score which details how an incident should be investigated. Only IG incidents which score at level 2 are reportable and are escalated to the Information Commissioner's Office (ICO).

During 2018/19, two information governance incidents were reported to the ICO (no incident in 2017/18) as outlined below:

Date of Incident	Summary of Incident	Volume	ICO Informed	ICO Action Date	ICO Action
30/08/2018	Three patients were given each other's scan reports containing confidential information in the Maternity Department. Patients were notified and asked to return incorrect scan reports. Confirmation given that a copy of correct scan report has since been given to patient 1, and correct report to be given to patient 2 at earliest opportunity, but the partner of patient 3 refused to return the copy of the scan report belonging to patient 1 given in error.	3	31/08/2018	23/03/2019	No further action required
09/01/2019	Specialist midwife's car was broken into while it was parked in the driveway of the midwife's home. The car was locked at the time. Patient records containing PII were stored in a padlocked trolley bag which had unintentionally been left in the car overnight and trolley bag stolen from the boot. Stolen paperwork included ante natal trackers and booking forms	35	11/01/2019	14/01/2019	No further action required

3.7.8 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

More information on the steps which have been put in place to assure the board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data are provided in Annex 2 of the Quality Report.

3.7.9 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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality account report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and 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 committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed in a number of ways:

- Dialogue with executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control, the risk management system and the Board assurance framework;
- The work of internal audit throughout the year to review and report on control, governance and risk management processes, based on an audit plan approved by the Audit Committee;
- In-year reports from the Audit Committee and the Quality Assurance Committee/Quality Committee in common;
- The Trust's Senior Information Risk Owner (SIRO), who has advised me specifically on the control of information risks;
- Integrated performance reports to the Trust Board at Board meetings and Board Development Days showing performance against NHS Improvement compliance framework and local targets;
- The results of patient and staff surveys;
- Close monitoring of financial performance and maintenance of cash flow and liquidity;
- Recognition of the dynamic nature of assurance and the work that has been undertaken to further develop the Trust's Board assurance framework;
- Review of external assessments and reports including the Care Quality Commission's published Quality Risk Profile.

3.7.10 Head of Internal Audit Opinion

The Head of Internal Audit's opinion is as follows:

"TIAA is satisfied that, for the areas reviewed during the year, Southend University Hospital NHS Foundation Trust has reasonable and effective risk management, control and governance processes in place.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by the Trust from its various sources of assurance."

TIAA carried out 13 reviews, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided.

One substantial assurance report and ten reasonable assurance reports contributed to the overall opinion above. Limited assurance reports were received in two areas with regards to medicines management and workforce utilisation. Management have agreed actions to address all the issues raised in these reviews.

3.7.11 Conclusion

I am aware that risks remain in relation to the Trust's financial performance and achievement of operational performance standards. However, the Trust has a well-developed financial plan for the year ahead and has agreed trajectories for performance standard improvement.

Whilst being aware of the risks cited, my review does confirm that Southend University Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. As noted in the "risk and control framework" section of this AGS, our risk management and governance processes will continue to evolve to address the challenges and exploit the opportunities associated with service transformation across the three trusts, not least the anticipated patient benefits of the proposed merger from April 2020.

I confirm that no significant internal control issues have been identified.

Clare Panniker
Chief Executive
29 May 2019

4. Quality Report

4.1 Introduction

NHS foundation trusts are required by the Health Act 2009 to publish an annual quality account as set out in the National Health Service (Quality Accounts) Regulations and NHS Improvement also requires NHS foundation trusts to produce quality reports as part of their annual reports.

The aim of quality reports is to help trusts improve public accountability for the quality of care they provide and ensure patients know they are receiving the best quality of care. Foundation trusts are also required to obtain external assurance on their quality reports subjecting them to independent scrutiny. During the course of producing the quality report, a number of key stakeholders such as the clinical commissioning groups, Healthwatch, governors and staff have had an opportunity to comment on the quality priorities. This report provides information about the quality of care it delivers, progress against the quality measures over the last 12 months and describes the priorities for improvement in 2019/20.

The report has been written with patients and the public in mind and should be as easy to read as possible. In some instances where the use of non-technical language has not been possible, a glossary has been included at the end of the report to explain any terms.

The quality report is set out in three sections:

Part 1: Statement on quality from the Chief Executive of the NHS Foundation Trust

A statement from the Chief Executive, Clare Panniker summarises her view of the quality of health services that were provided or sub-contracted during 2018/19.

Part 2: Priorities for improvement and statements of assurance from the Board

In this section we focus on our progress against achieving the quality priorities set out for 2018/19 and we also look to the future by describing our key priorities for 2019/20. This section also includes a series of statements of assurance from the Board on particular points as set out in the NHSi detailed requirements for quality reports 2018/19.

Part 3: Other information

This section is used to present information on how we have performed in relation to the quality of services and other achievements made during 2018/19.

4.2 Part 1 Statement on quality from the Chief Executive

I am delighted to introduce the quality report 2018/19 for Southend University Hospital NHS Foundation Trust, which is the third quality report I have overseen for the Trust since becoming the Chief Executive.

Our ambition is to improve health and wellbeing, through excellent and sustainable services provided by staff supported to develop, innovate and build rewarding careers. This is only possible through the continued determination and drive of our staff working collaboratively across Mid Essex, Basildon and Southend Hospital and moving towards the merger of the three Trusts. I am pleased to announce that for the first time, all three Trusts have come together to review and agree the shared quality priorities for 2019/20 which will ensure we can deliver greater improvements either through scale or approach. 2019/20 will be a pivotal year for all three trusts as we move towards the merger and having a clear set of shared priorities based on key deliverables is an important step in ensuring we are all moving in the same direction and with the same purpose.

During the year we took the decision to move to having a new Quality Committee in Common that oversees and monitors the quality priorities and strategy. This is helping us to ensure there is alignment of risks, a group-wide approach to regulatory compliance and to maximise learning from inspection reports, incidents, complaints and claims across the group.

We have been faced with many challenges again this year with a particular emphasis on the increased demand on our services. The high level of emergency attendances, high patient acuity and high staff vacancies has meant that we have not been able to deliver all of the quality priorities we set out for 2018/19 as we had hoped. However, staff remains committed to delivering the best possible care for our patients, ensuring that they have the best experience possible and achieve good outcomes. I am pleased to report that with the hard work and dedication of many staff, the mortality rate for the trust, reported in the Summary Hospital-level Mortality Indicator is now within the expected limits. The mortality reduction programme has seen changes such as the implementation of the Medical Examiner role, the implementation of the learning from deaths framework and mortality review system (SMART), improvements to clinical coding and the impact of opening the dedicated High Dependency Unit.

In April 2018, the Care Quality Commission published their report into the inspection of services at Southend University Hospital which demonstrated a significant improvement in most areas inspected. The Trust is continuing with its 'Maintaining High Standards' programme to ensure that there is continual assessment and improvement against the CQC key lines of enquiry and expected standards and regulations. During 2018/19, there have been positive reviews of our services by the clinical commissioning groups and other external bodies such as 'Getting it Right First Time' (GIRFT) which is helping us to identify further areas improvement in addition to celebrating the achievements in the areas where we are performing well.

In the quality account we report on the improvements we have made during 2018/19 and describe our quality plans and priorities for the future. I confirm that to the best of my knowledge, the information contained in this document is accurate.

Clare Panniker
Chief Executive
29 May 2019

4.3 Part 2: Priorities for improvement and statements of assurance from the Board

4.3.1 Progress against priorities for improvement 2018/19

The Trust vision is to be a leading provider of seamless healthcare which supports every person that needs the Trust's services, whether in or out of hospital to achieve their best health possible. The strategic aims underpinning this vision are to deliver excellent patient outcomes and patient experience which are achieved through consistently reviewing and improving the quality of care that is delivered. We recognise the importance of valued and motivated staff and the Trust values of caring with compassion, working together and being professional and accountable support all staff to strive for the provision of high quality, consistent care and maintain quality as a top priority.

A quality improvement programme is in place with priorities aimed at ensuring continual quality improvement is embedded into normal practice and supports the Trust with the aim of achieving a 'Good' rating by the Care Quality Commission. In November 2018 the MSB group established a vision for embedding quality improvement across the group which includes a number of initiatives to build quality improvement capability among staff. This includes continuing to develop staff through the quality, service improvement and redesign (QSIR) programme and improving the specialist support available from the MSB quality improvement faculty.

The key quality priorities detailed in this report are centred on three key domains of quality; patient safety, patient experience and clinical effectiveness.

Patient Safety

This domain focuses on ensuring that we do not harm our patients and that we are maintaining services that provide care in a safe way. This means that we aim to reduce avoidable harm such as falls, pressure ulcers and healthcare associated infections and that we respond to patients in a timely and appropriate way if they deteriorate.

Clinical effectiveness

This is about doing the right thing, in the right way, for the right patients at the right time. We use information from a variety of sources to monitor our success rates and clinical outcomes such as mortality rates, unintended re-admissions to hospital and lengths of stay.

Patient experience

Ensuring patients have a good experience when they access our services is important to us and we strive to make sure that every patient is treated with dignity, respect and receives compassionate care. We recognise that sometimes we do not always get things right every time, and therefore we ensure that we have systems in place to listen to and respond to service users and their family or carers when they have concerns.

Achievements against the 2018/19 quality priorities

This section of the quality report includes an overview of the quality of care based on performance in 2018/19 against the indicators selected by the Board in consultation with stakeholders. The quality priorities were selected based on three domains: patient safety, clinical effectiveness and patient experience. Some of the quality goals that were agreed in 2016/17 remained a priority for 2017/18 and 2018/19 and a summary of performance against these are reported in the table below.

Table 35: Performance against agreed quality goals

Domain	Priority for improvement	Measure	Target Date	Achievement
Patient Safety	Reducing harm from deterioration	Reducing summary hospital-level mortality indicator; reducing avoidable cardiac arrests; reducing 30 day mortality from sepsis	March 2019	Achieved
	Reducing avoidable harm	Reduce in-hospital falls and preventable pressure ulcers and fully embed the ward accreditation programme	March 2019	Progress made towards achievement
	Safe staffing	Achieve safe nursing staff levels	March 2019	Good progress made and achieved in part
Patient experience	Improving patient feedback	Improve the recommender score for friends and family test	March 2019	In progress, not yet achieved
	Improving patient engagement	Improve the patient engagement score in the national inpatient survey	March 2019	In progress, not yet achieved
	Embedding staff values	Improve the recommender score from the staff friends and family test	March 2018	Achieved
Clinical effectiveness	Improving patient flow	Achievement against key operational targets – 62 day cancer, 4 hour A&E and referral to treatment targets	March 2018	In progress, not yet achieved

Patient Safety Priorities 2018/19

Reducing harm from deterioration

To support the priority of ensuring we are providing safe care we recognise the importance of identifying when patients are deteriorating and ensure that we respond in in appropriate and timely way. We identified a number of key areas for improvement to ensure that appropriate decisions are made for our patients at the earliest opportunity regarding escalation, resuscitation and treatment pathways.

Our aims

- Reduce the summary hospital-level mortality indicator (SHMI) to within expected limits (1.117) by March 2019
- Sustain the reduction in avoidable cardiac arrests at 1.00 per 1,000 admissions or less by March 2019.
- Sustain the reduction in 30 day mortality associated with sepsis at 26% by March 2019

The Trust Mortality Surveillance Group co-ordinates and oversees the plans and improvement actions being taken by the Trust in relation to mortality and morbidity. This includes the implementation of the learning from death framework, deteriorating patient programme, timely identification and treatment of sepsis and reviewing outcomes from in-hospital cardiac arrests.

Summary Hospital-level Mortality Indicator (SHMI)

Since the beginning of 2018/2019 Southend University Hospital NHS Foundation Trust has made huge strides in understanding and improving in-hospital mortality which is evident in the improvement in the Standardised Hospital Mortality indicator which is now within the expected range. More information on this improvement can be found in section 4.3.4 of the report.

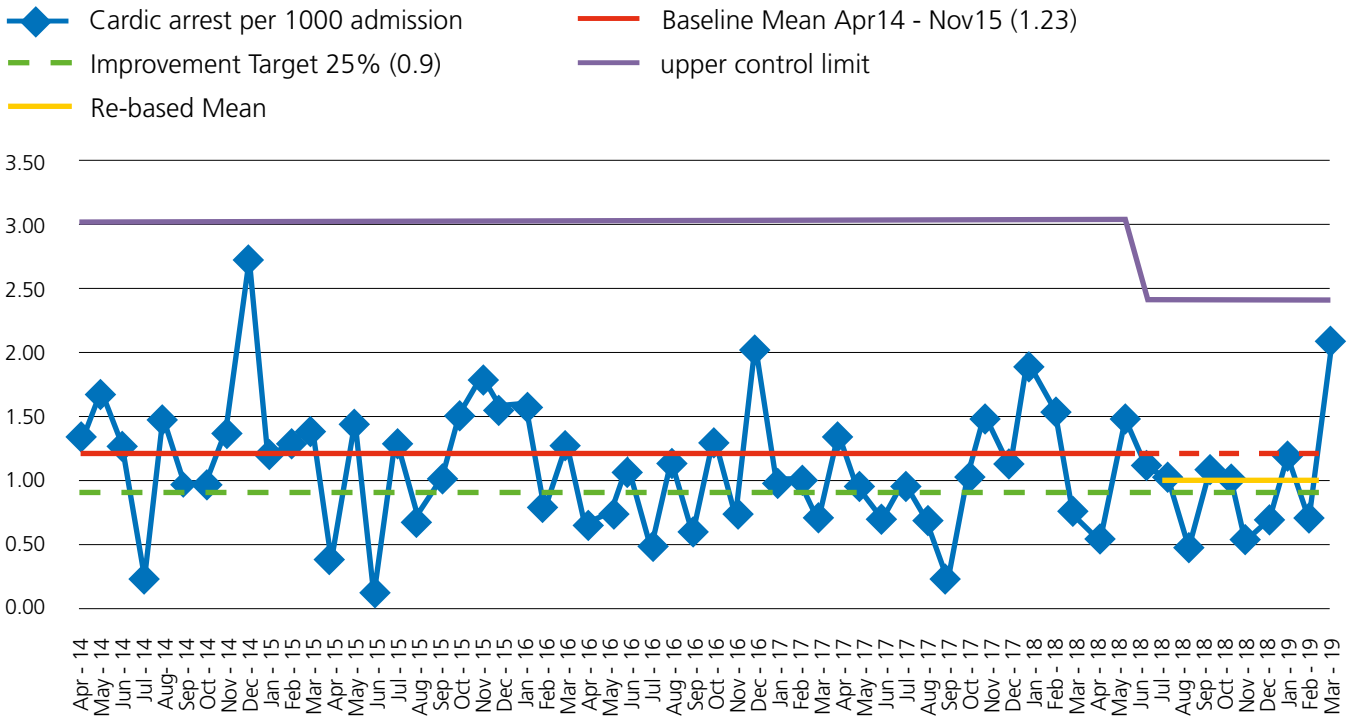
Avoidable cardiac arrests

Cardiac arrest audit data is available nationally from the National Cardiac Arrest Audit. However this data includes all calls to the cardiac arrest team (known as 2222 calls) regardless of whether the call relates to a current hospital patient and therefore cannot be used as a national benchmark for this improvement indicator. The indicator chosen by the Trust includes only cardiac arrests in patients currently under the care of the hospital (inpatients or outpatients attending an appointment).

We aimed to sustain the improvement seen in 2017/18 by maintaining our reduction in cardiac arrests at 1.00 per 1000 admissions or less by March 2019.

Between June 2018 and February 2019 the rate of cardiac arrests has remained below the baseline mean of 1.23. The median for 2018/19 is 0.99 which is below the baseline and slightly above the target of 0.9. There was a spike in March 2019 with the number of cardiac arrests being double the usual rate. A deep dive has been conducted of all cases and no concerns identified. We continue to undertake cardiac arrest reviews as soon as possible after the event and the outcomes will continue to be presented at the Mortality Surveillance Group.

Figure 8: cardiac arrests per 1,000 admissions - Local data source



Since February 2017 all doctors, including new starters, receive training on treatment escalation plans (TEP) and 'do not resuscitate' (DNACPR) decisions, which is delivered during mandatory training sessions and repeated annually. In October 2017 the Trust implemented a revised deteriorating patient pathway which generates a peri-arrest call on all patients who have a national early warning (NEWS) score of greater than 10, providing their TEP identifies this as appropriate. This is facilitating the rapid identification and appropriate senior evaluation of the deteriorating patient. A review of the levels of nurse training in the deteriorating patient has been carried out.

In spring 2019 we will implement a revised TEP form and new requirement for this is completed for every patient admitted to the hospital. We will aim to introduce a brief 'huddle' after each emergency call to evaluate the appropriateness of the call and to debrief the team. In conjunction with this, a feedback process will be instigated to highlight to the consultant in charge of the team, those patients in whom we believe there was a missed opportunity to complete a TEP and DNACPR in advance of a cardiac arrest.

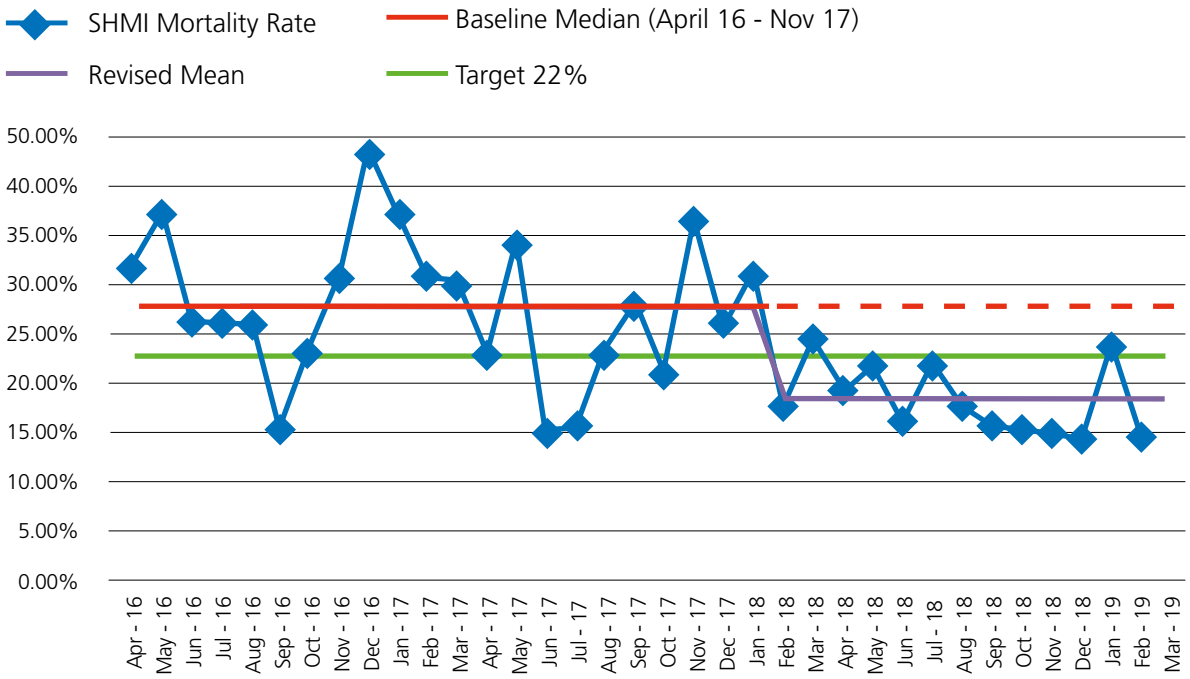
30-day mortality associated with sepsis

Timely identification and treatment of sepsis within the emergency department (ED) and inpatient wards is a key driver to reducing 30 day mortality associated with sepsis.

There is a downward shift with the 30 day mortality associated with sepsis which can be seen from February 2018 when the mortality rates fell below the baseline mean and has remained there for thirteen months (see Figure 9 below). The baseline mean has been recalculated using QSIR methodology ensuring there are at least 20 data points and is 27.29% and the target has been reset at 22% (20% reduction from the baseline). The re-calculated mean from February 2018 to February 2019 is now 18.24%, which is below the target rate of 22%.

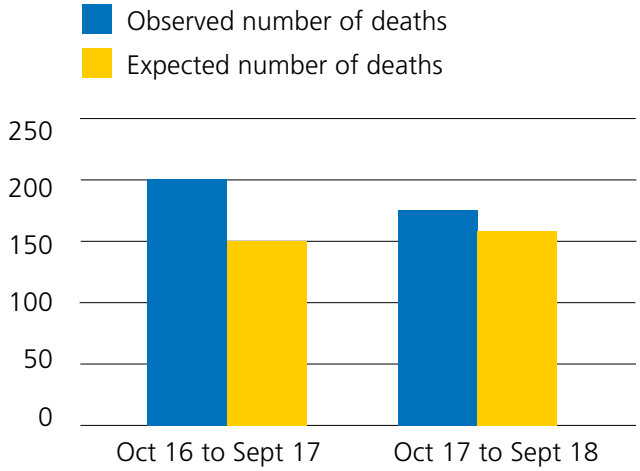
Figure 9: sepsis related deaths – in-hospital or within 30 days of discharge - Local data source

Sepsis - In-hospital death or within 30 days of discharge



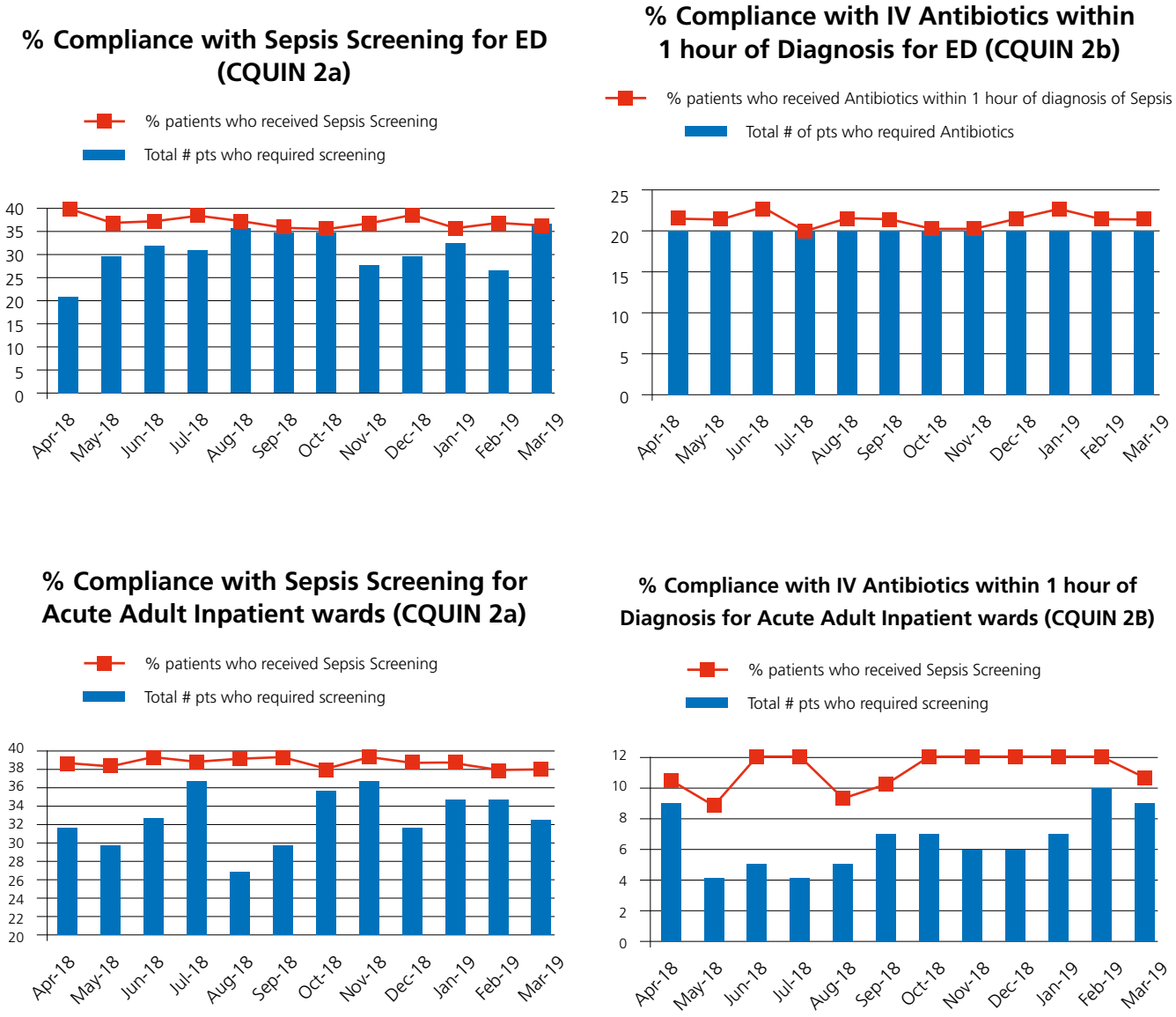
Benchmark data is available from NHS digital using the summary hospital-level mortality indicator (SHMI) which enables the data to be broken down by diagnostic groups. Figure 10 shows the observed number of deaths versus the expected number of deaths for septicaemia (except in labour), the difference between both has reduced progressively for the five SHMI reporting periods since September 2016. On-going work continues with the coding department to review all deaths relating to sepsis as well as review of notes where sepsis was coded within their admission episode. These give assurance that coding is appropriate, identifying good practice and ensuring lessons are learnt and shared which continues to have a positive impact on the number of deaths associated with sepsis.

Figure 10: Septicaemia (except in labour), shock – observed versus expected number of deaths – SHMI data October 2016 – September 2018 NHS Digital



Our performance against sepsis screening and the timely administration of antibiotics has continued to be maintained above the 90% target set by the National Sepsis CQUIN. The only variable figure is the inpatient time to administration of IV antibiotics which varies between 75% and 100% although the denominator is small and therefore should be viewed with caution. However for quarter 3 this figure remains stable at 100%.

Figure 11: Compliance with national sepsis CQUIN targets – local data source



A Patient Group Direction (PGD) and accompanying competencies for senior nursing staff has been written awaiting approval and the aim of this initiative is to reduce the risk of delay in prescribing the initial dose of IV antibiotics.

Although we remain above the targets for patients with sepsis in the emergency department, feedback continues to be provided to the multidisciplinary team on cases where screening has not and should have occurred for learning.

Reduce avoidable harm events

The Trust supports the Sign Up to Safety campaign aims to deliver harm free care for every patient, every time and sets out to reduce avoidable harm in the NHS by half over three years. We aim to increase the percentage of patients experiencing harm free care by reducing harm events.

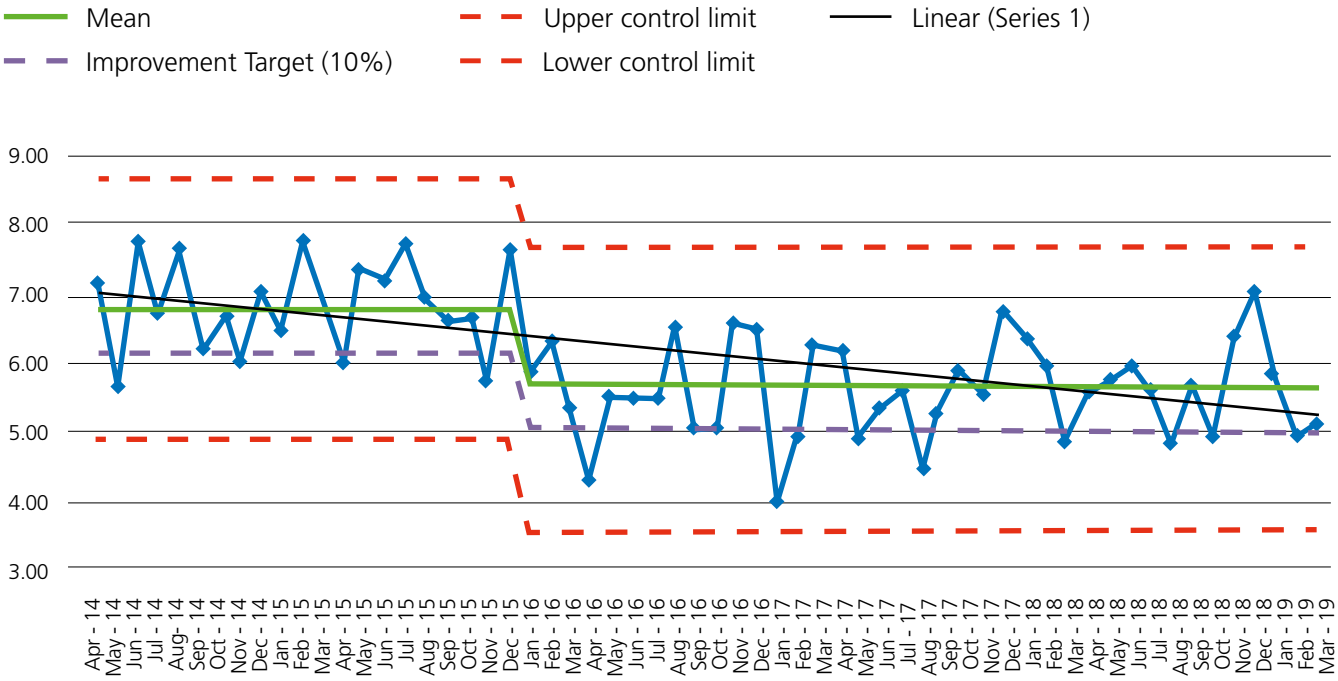
Our aims

- Continue to reduce in-hospital falls by a further 10% from baseline of 5.63 per 1,000 occupied bed days to 5.07 by March 2019.
- Reduce preventable pressure ulcers by 30% from baseline of 0.11% of admissions to 0.08% by March 2019.
- Fully embed the ward accreditation programme by March 2019.

Reduce in-hospital falls

The reduction in falls per 1,000 bed days continues and for 2018/19 has been sustained below the original baseline of 6.81, with an average of 5.72 falls (April 2018 to March 2019). We did not achieve the 10% reduction planned for 2018/19 but we continue to see a downward trend towards a reduction with in-hospital falls to 5.07 per 1000 bed days.

Figure 12: Falls per 1000 occupied bed days – local data source



Current projects around falls prevention include the introduction of enhanced competencies for the Care of the Elderly Wards and "bite sized" training sessions on the Stroke unit. Wards continue with their falls prevention initiatives such as 'Baywatch' which improves the vigilance within patient bays and is helping to prevent potentially vulnerable patients from falling.

Two multi-professional simulation training days have been held for Nurses, Doctors, HCAs and Allied Health Professionals and further sessions are being planned for spring / summery 2019. Training has also been completed for the incoming newly qualified nurses and junior doctors.

The introduction of the Pressure Ulcer and Falls Safety panel process this year ensures that all falls resulting in moderate or above harms are scrutinised by a multidisciplinary team and that lessons learnt are translated into meaningful actions and learning.

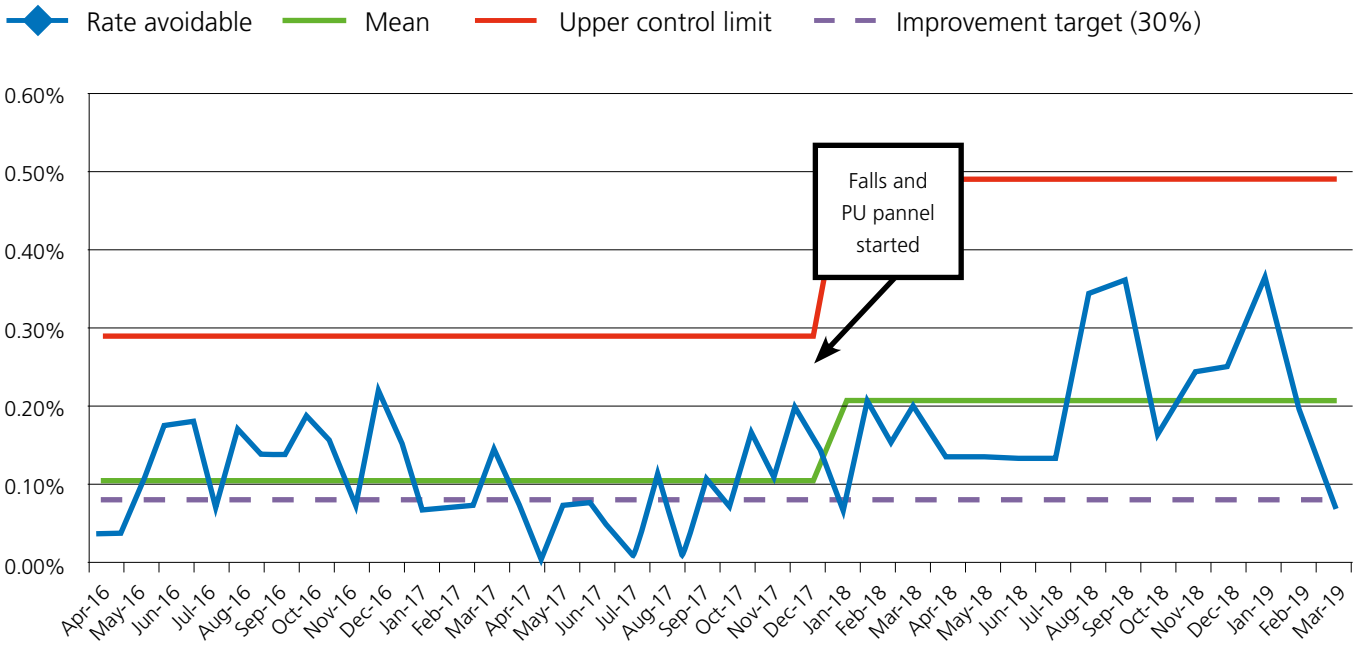
Reduce preventable pressure ulcers

Pressure ulcers are seen as an indicator of the quality of care provision. Both inherited and hospital acquired pressure ulcers (HAPU) are monitored and where a HAPU is identified as category 2, 3, 4 or unstageable, an incident is raised and an investigation is carried out to determine whether there have been lapses in care (preventable) or not. A pressure ulcer is deemed to be preventable when lapses in delivering pressure ulcer care results in a patient sustaining pressure damage. Unpreventable damage is only recorded when every intervention to prevent damage has been put in place or where this has been offered but declined.

There is currently no benchmark data available across trusts due to the variability in reporting between different trusts. The percentage of pressure ulcers with lapses in care against admissions has increased during the year which was expected. In February 2018, the Trust introduced a new weekly review panel meeting for all hospital acquired pressure ulcers category 2 and above. This new process increased the scrutiny on all pressure ulcers (category 2 and above) and requires wards to conduct an initial investigation when a pressure ulcer is identified. The outcome of the review is presented to the panel the following week to determine whether there were any lapses in care.

This more robust process has resulted in an increase in the number of pressure ulcers with lapses in care being reported, which we anticipated would occur. This can be seen in Figure 13 which shows from January 2018 to March 2019 there were 14 data points above the baseline mean. The mean and upper control limits were recalculated from January 2018 which shows an increase from 0.11% to 0.21%. We now have a new baseline upon which to base our improvement target for 2019/20.

Figure 13: preventable pressure ulcers as a percentage of admissions - Local data source



The tissue viability team took advantage of the Stop the Pressure campaign day on 15 November 2018 to highlight and reinforce the pressure ulcer prevention messages to ward staff. A public information stand in the main corridor attracted lots of interest for both staff and relatives who were passing; information leaflets were handed out in order to raise awareness of pressure ulcer prevention; Activities and information for staff were available throughout the day in the Ambulatory Wound Unit on Balmoral Ward and the staff who visited were keen to discuss challenging scenarios they had experienced and to share ideas.

The tissue viability team introduced a number of initiatives during the year to support the improvement work such as producing new training material, updating the pressure ulcer policy to reflect the new pressure ulcer guidance from NHSi, developing patient information leaflets, evaluation of static pressure reliving cushions and improving ward engagement through SSKIN champions and allocating a names tissue viability nurse to each area. A review of pressure ulcer documentation was also carried and the updated care round documentation is being piloted. The tissue viability team continue to provide training and additional training dates are planned for 2019/20.

A review of the pressure ulcer reporting process was carried out in 2018/19 and the new processes is being embedded to ensure data is accurate and produced in a timely manner.

Further initiatives which are currently in progress include the pressure ulcer safety cross pilot across 8 wards, an evaluation with a range of heel lift devices and pressure reducing pads, the development of a credit card size information card for staff covering the SSKIN framework and pressure ulcer categorisation and the new heel care pathway which has been produced.

Initiatives to address shortfalls in care are also being implemented clinically at ward level as a result of learning from recent hospital-acquired pressure ulcers with lapses in care.

Embed the ward accreditation programme

During 2017/18 a pilot project was completed of the ward accreditation scheme with the aim of rolling this out across all three hospitals (Mid Essex, Southend and Basildon) during 2018/19. This was selected as a quality priority for 2018/19 as these schemes have been shown to promote safe patient care by motivating staff and sharing best practice between wards and would support the quality priorities. Unfortunately the agreement by corporate nursing teams to continue with the project and provide suitable funding was not achieved during the year hence this project has not continued.

Safe staffing

The trust aims to achieve safe staffing levels as indicated by the Safer Nursing Care Tool (SNCT) with permanent staff by March 2019. The SNCT provides recommended staffing levels based on acuity and dependency of patients. A further review of current staffing establishments and skill mix within the Trust compared with SNCT assessment and Professional Judgment took place in December 2018 across the three MSB Trusts and a report has been presented.

Staffing levels and fill rates are reported quarterly to the Trust board and nationally. Staffing is reported nationally on a monthly basis reporting fill rates and CHPPD (care hours per patient day). Vacancies are monitored within the quarterly staffing reports for the trust and specific areas with high vacancies are highlighted. Monthly comparisons with staff in post, vacancy whole time equivalent (wte) and vacancy percentages are presented in the report. Table 36 below shows these for 2018/19.

Table 36: Staffing data for quarters 1 - 4

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Staff in post	710.2	722.29	719.69	711.08	701.46	697.12	743.85	744.62	739.06	720.71	727.77	730.65
vacancies WTE	129.52	138.5	146.48	154.98	157.91	166.92	128.34	135.87	130.43	122.98	115.92	113.04
Vacancy rate (%)	15.26	16.09	16.91	17.89	18.38	19.32	14.71	15.43	15.00	14.58	13.74	13.40

A senior nurse is responsible for monitoring nurse staffing levels on a daily basis in consultation with department matrons and heads of nursing. Patient acuity and dependency is monitored and staffing levels assessed to maintain safe levels of staffing. In December 2018, 'Safe Care' was introduced which is a component of E-roster and provides live staffing information on a shift to shift basis including CHPPD, professional judgement decisions and an auditable record of staff redeployment. This will also provide compliance with the recommendations in the NHSI CHPPD guidance for Acute and Specialist Trusts (June 2018).

A recruitment plan is in place, led by the recruitment and retention task and finish group, to address the registered nursing deficit within the trust. A monthly dashboard focussing on recruitment and retention is presented which provides data on leavers from the Trust for the current month and the preceding year. Areas with higher turnover than the Trust level are highlighted and discussions take place with the directorate and actions put in place. All staff that are within two years of retirement have been offered Pre-retirement workshops and the Retire and Return information pack.

The number of registered nurse leavers for leavers for 2018/19 is shown in the table below.

Table 37: Registered nurse voluntary leavers

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
RN voluntary leavers	18	12	8	16	19	14	14	20	17	17	15	5

Recruitment days are held quarterly where attendees can meet with the Matrons and recruitment leads to discuss opportunities in the Trust, overseas nurses are given advice about English language requirements and advised to contact the Nursing and Midwifery Council (NMC) and bank nurses are interviewed on the day and offered positions on the nurse bank. In quarter 4, eight nurses from overseas recruitment commenced in the Trust and Skype interviews have continued. Overseas Nurses are supported to take the NMC OSCE practical exam and our current pass rate is 100%. Interviews and engagement with Students Nurses who were due to qualify in March 2019 have continued throughout Quarter 4.

A Number of Healthcare Assistants (HCA's) within the Trust have completed higher apprenticeships and are employed in band 4 roles which are utilised to mitigate registered nurse deficits. The Trust is part of a Mid Essex STP partnership piloting a nursing associate programme which commenced in December 2018.

Trust staff have attended engagement events with school leavers in the local community to promote nursing and NHS careers to school leavers. Engagement events have also been held community groups supported by the local council to support people to return to work.

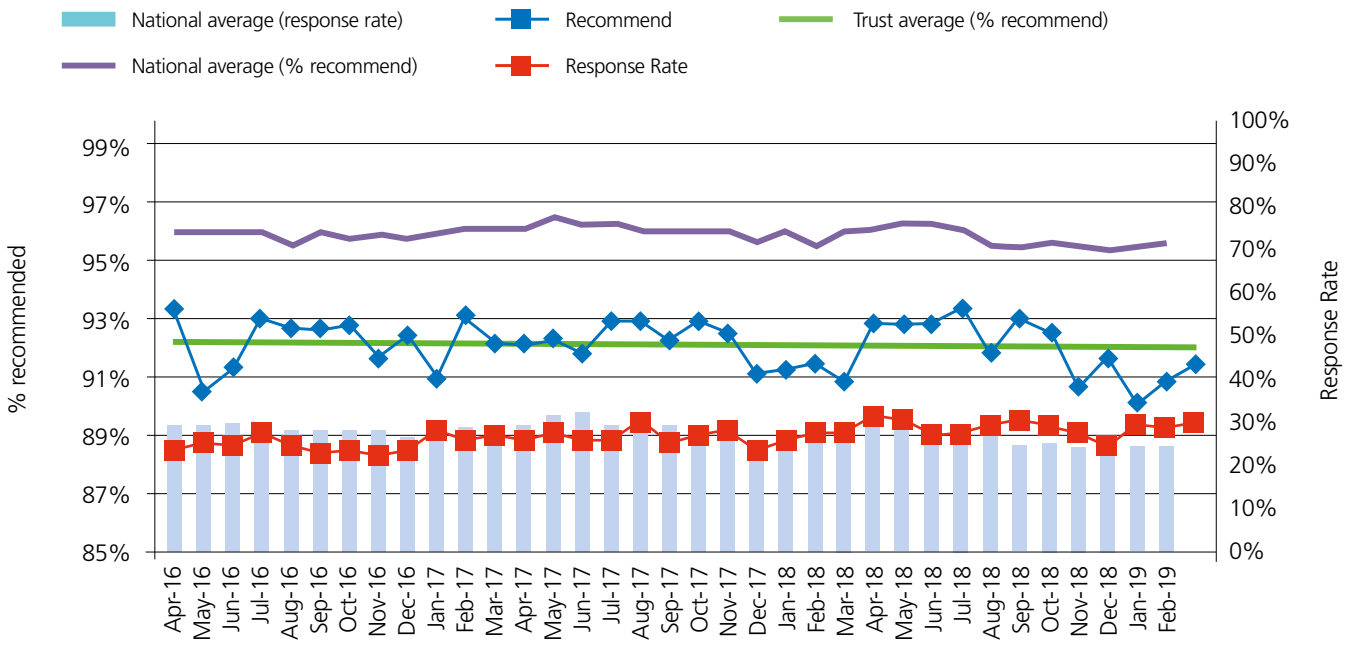
As part of the recruitment and retention review it has been highlighted that there are concerns in relation to the effectiveness of the HCA recruitment due to the number of staff leaving soon after commencement of employment. A pilot to provide an assessment day for HCA recruitment to ensure appropriate staff are recruited to the Trust has commenced in January 2019. Further assessments took place in February and March, permanent and bank roles were interviewed and offered at these events. There is also a plan to develop a workforce plan identifying plans to develop Healthcare Support worker roles to address anticipated workforce deficits across the MSB and how these will be incorporated into the nursing workforce plan.

Patient experience priorities 2018/19

Patient feedback

Providing a positive patient experience is a fundamental aspect of good quality healthcare and links to the overall trust five year strategy and quality priorities to provide excellent patient experience. The trust takes part in the national Friends and Family Test (FFT) and uses this data to benchmark patient experience with similar acute trusts. We aim to improve the percentage of patients who would recommend the Trust to ≥95% for inpatients and ≥90% for the Emergency Department (ED) patients by March 2019.

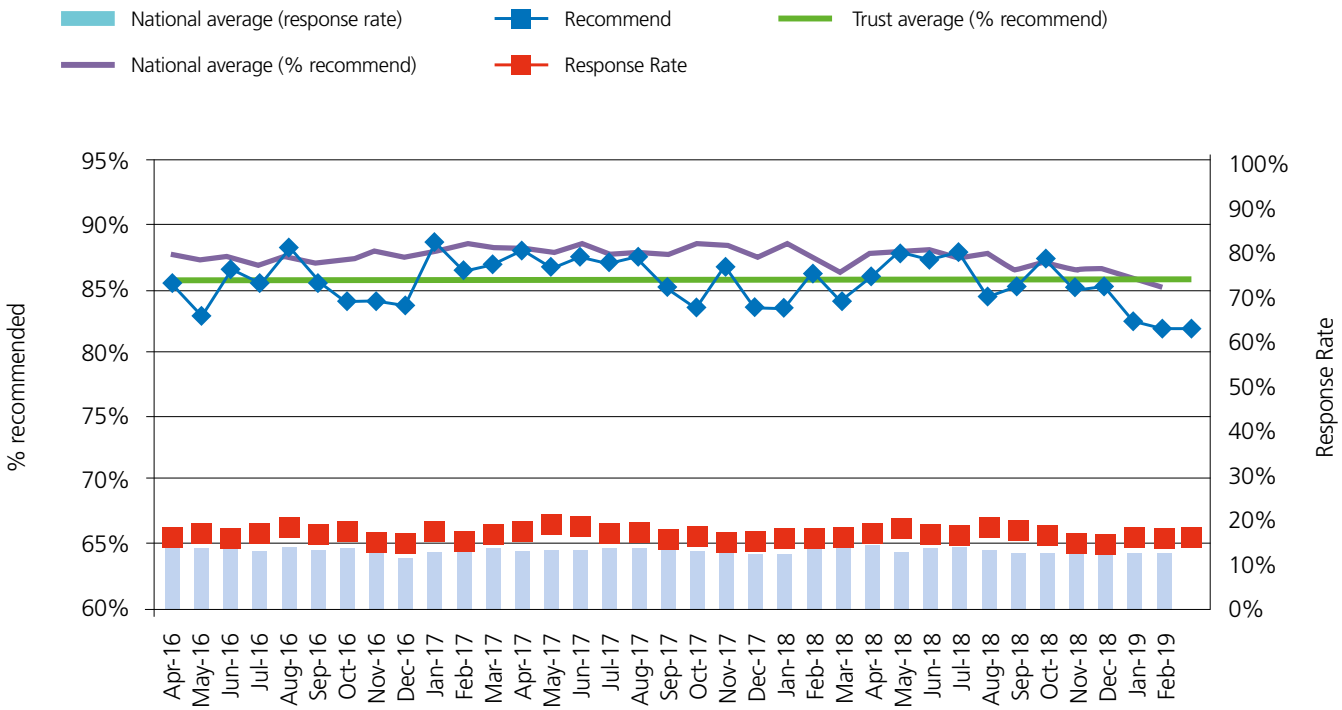
Figure 14: inpatient and day case friends and family scores and response rates - Local data source and NHS Digital



For 2018/19 the response rates for inpatient and day cases improved overall by 1.68%. The response rate dipped slightly in December which is a trend we often see each year around the festive period. However, our results have been above the national average since July 2018 to date.

The percentage of patients that would recommend has fluctuated throughout the year, peaking in July at 93.41% (target 95%). Positive comments continue to be received within all directorates and specifically themes relating to staff being courteous, kind, efficient and professional and many comments were made about staff and teams working well together despite challenges. These continue to be shared with the teams. Negative themes from comments relate to poor communication, especially around treatment plans and discharge, waiting for beds and waiting for treatment/ discharge from hospital. All negative comments are shared with the directorates and our Patient Experience Team record action taken and improvements made.

Figure 15: Emergency department friends and family scores and response rates - Local data source and NHS Digital



We need to continue to work on increasing the recommender scores for the ED by a further 4% in order to achieve our target of 90%. We will continue with our monthly analysis into the comments received within the FFT feedback to identify themes and any areas of concern which we address with the ED directly.

The response rate for the emergency department (ED) has remained above the national average again this year, reporting an average score of 15.65%. The percentage of emergency department (ED) patients that would recommend the Trust is only slightly below the national average at 85.26% (target 90%). The majority of feedback received for the ED is positive. Themes identified in the positive comments included waiting times, staff being reassuring, clean environment, dignity and professionalism. Negative comments were made in relation to waiting times, staff attitudes, delays in providing pain relief and clinical treatment.

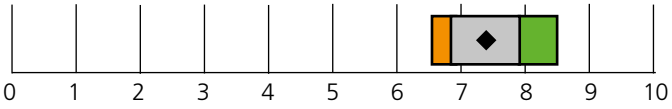
Patient engagement

Southend University Hospital NHS Foundation Trust is committed to developing an inclusive approach in engaging people more in their care and treatment and in developing plans for service provision. The patient engagement strategy (approved in July 2016) supports the Trust's five-year strategy and determines how the Trust is committed to working in partnership with patients and sets out a three-year implementation plan.

We aim to improve our national inpatient survey score for the question regarding patients being involved in decisions about their care and treatment by 0.5 points to 7.7 (0 being the worse possible score and 10 being the best) by March 2019. This will bring us within the second quartile of reporting trusts (previously in the third quartile).

The data for the 2018 adult inpatient survey is not due to be published until May / June 2019. Our score for this question on the 2017 National Inpatient Survey was 7.3, an improvement of 0.3 compared with our score of 7 in 2016. We will continue to work towards improving this score by completing local bespoke surveys to monitor the best/ worst performing areas and thoroughly analyse the data to identify any staff training needs.

Q34. Were you involved as much as you wanted to be in decisions about your care and treatment?



Although we remain in the third quartile of Trusts for the involvement score, the results of our 2017 National Inpatient Survey highlighted one amber rated section related to feedback on the following question: *"During your hospital stay, were you ever asked to give your views on the quality of your care?"*

The Trust scored '1.0/10' for this question, the same score was received in the 2016 survey. The highest score in England was 3.6/10 and the lowest score was 0.7. Therefore overall the national scores were poor in answer to this question.

Q69 During your hospital stay, were you ever asked to give your views on the quality of your care?

Our priority for 2019/2020 therefore will be to improve our engagement with patients and encourage more feedback from patients about the quality of the care they receive. Our objective is to improve our score to this question on the National Inpatient Survey by at least 1 point by March 2021 to 2.0 or above which would bring the trust in line with the national average score for this question.

We aim to do this by further promoting the FFT test to improve participation, increase the use of our bespoke inpatient surveys mirroring the same question to gather further intelligence. We will also continue to monitor patient feedback via our schedule of CQC mock inspections which includes asking patients their views during their episode of care.

Staff values

We will continue to improve patient care by focusing on embedding the Trust values and improving leadership. We will continue to measure the staff friend and family test on a quarterly basis and use the national staff survey to benchmark with other acute providers.

The Trust aimed to improve staff engagement over the year and views the annual NHS staff survey as a good measurement tool to see how well values have been embedded. Research shows that when staff are engaged and feel valued, this impacts on their practice and patient experience.

In the 2017 survey Southend University Hospital NHS Foundation Trust ranked in the lowest 20% of NHS acute trusts for this indicator. However in 2018 the trust's score rose to 6.9 (NHS Acute Trust Average is 7.0) and therefore the Trust is no longer in the bottom 20% (see table 38 below).

Table 38: Staff survey – NHS acute trust

Period	Trust result	National average	National lowest	National highest
2014	6.5	6.8	5.9	7.5
2015	6.8	7.0	6.4	7.6
2016	6.8	7.0	6.5	7.4
2017	6.8	7.0	6.4	7.4
2018	6.9	7.0	6.4	7.6

Below are the actions being undertaken across the group relating to employee engagement:

- NHSI Culture audit is completed and we are working with NHSI colleagues to turn the recommendations from this report into a meaningful change programme.
- Listening Events are planned for April and May 2019 to work with staff on our key issues. The sessions in Quarter 1 relate to recruitment and dignity & respect.
- Daily briefing sessions are held by the Site Leadership team at 8.30 every weekday for staff to raise concerns.
- Regular updates are provided to all staff on the merger plans and progress
- Anti-bullying and harassment campaign continues to be rolled (Respect campaign)
- Senior Leadership Development College is now underway and senior leaders are attending with a second cohort planned for next quarter.
- Retention Skills Training for Managers has commenced including staff engagement toolkit
- Clinical engagement plans including consultant conferences and the consultant development programmes
- Staff Survey communication plan is in progress

Clinical effectiveness priorities 2018/19

Improving Patient Flow

We recognise the importance of improving patient flow and ensuring that all our patients receive the right treatment at the right time to maintain a safe and effective service and provide our patients with best possible experience.

Our aims

- **Four-hour accident and emergency target** - 95% of A&E attenders to be either admitted or treated and discharged within four hours of arrival by 30 June 2018. This is in line with the national target.
- **62-day target for cancer waits** - 85% of patients with cancer begin their treatment within 62 days of referral by 30 June 2018. This is in line with the national target.
- **Referral to Treatment (RTT) waiting time** - 92% of patients waiting to start treatment who have been waiting less than 18 weeks by 30 June 2018.

Performance is monitored against the above priorities on a continuous basis to ensure appropriate and timely response is achieved. The data is also reported on a monthly basis via the integrated quality and performance report which is reviewed by the Trust Board.

Four-hour accident and emergency target

2018-19 has been a challenging year seeing a steady increase in attendances by 7% on last year as well as more acutely unwell patients with Resus being far busier than previous years.

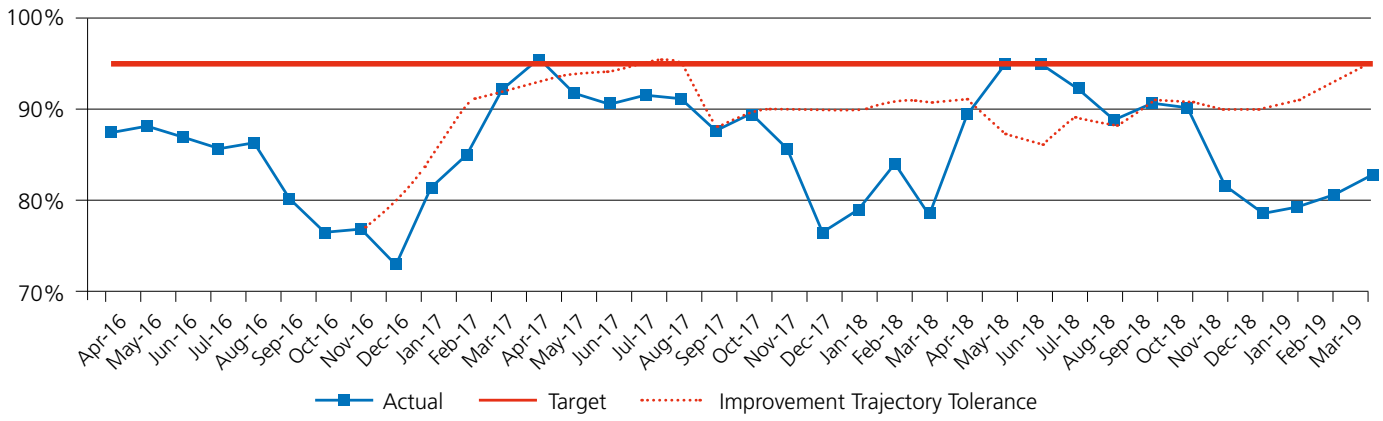
We have optimised and embedded a strong GP streaming service based on the Luton and Dunstable model. On average we are streaming 65 patients to the unit per day which has had a positive impact on our non-admitted performance. The GP service was recently rated as "Good" following their CQC inspection.

In April 2018 following our CQC inspection we started the first phase of opening our Paediatric Emergency Department 24/7 and the department is now open 24 hours a day from Friday to and including Monday, which is a huge step forward in providing appropriate 24 hour care for children. We are currently looking to recruit additional paediatric nurses to allow us to open every night and avoid children having to be treated within our adult ED.

In January 2019 we opened our new rapid assessment and treatment (RAT) area. This is a six bedded area used to receive ambulance arrivals allowing patients to have a rapid assessment by a senior clinician and patients can then be streamed with a clear plan. Our "RAT area" also supports the 'fit to sit' campaign allowing us to use a major's cubicle for step down patients.

Exit block continues to be a contributor to our poor performance, in January 2019 the medical directorate ran a perfect week supported by the Emergency Care Intensive Support Team (ECIST). This showed a decrease in exit block and an increase in senior decisions being made for medical patients within ED which showed an improvement in ED performance.

Figure 16: Compliance with four hour accident and emergency target - Local data source



Whilst our vacancy rates in the emergency department have remained high we are actively engaging with our recruitment teams to reduce this. We continue to use Extended Scope Practitioners (ESP), independent practitioners who can examine, diagnose and treat minor injuries and illnesses. We have also done a great deal of work recruiting Paramedics onto our bank to support our vacancy deficit and they have a dedicated competency programme which aligns to our nursing competencies. We have also recruited a social worker who is based in ED who works over both local authorities starting the social workup of patients straight away enabling us to prevent unnecessary admissions.

In May 2018 we introduced a new role, the "Emergency Flow Coordinator" (EFC) to support the patient journey and they play an important part in delivery of the 4 hour standard and allow the nursing staff to focus more on patient care and clinical duties and less on administration duties. The primary function of the EFC is to track the patient journey through the Emergency Department and resolve any actual or potential delays in treatment; they have played an important part in embedding Teletracking, a system used to improve the flow of patients from ED into the hospital. The introduction of Teletracking has reduced the number of phone calls between ED to the control room and the Acute Medical Unit.

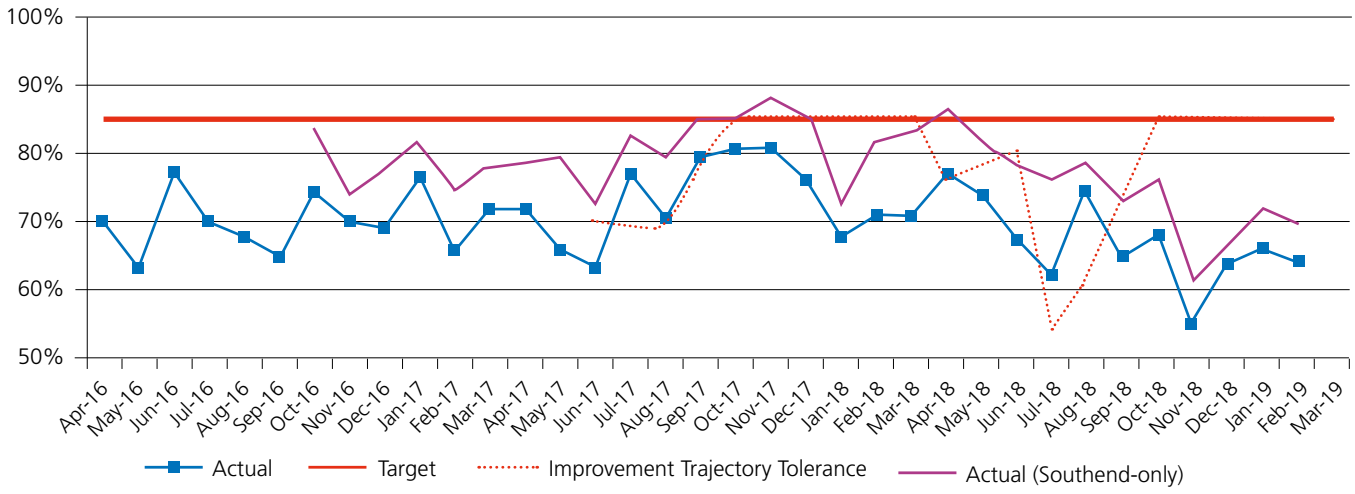
In November 2018 a new substantive consultant started which made our consultant body fully established, improving patient care and leadership within the department and reducing spend on agency consultants. We have also secured a twilight registrar thus providing better senior cover at peak times.

Following some national guidance relating to deteriorating patients, our practice development lead has put together an internal training programme for reception staff to enable them to identify and red flag potential deteriorating patients.

62-day target for cancer waits

Performance against the 62 day target for cancer waits was below the trajectory and plan in 2018/19. The Trust focused on reducing the patients waiting over 104 days and at the end of the year only 2 patients were waiting more than 104 for avoidable reasons (i.e. that the trust could have taken action to prevent the delay).

Figure 17: Compliance with 62-day target for cancer waits - Local data source



The trust improvement plan focussed on pathology, urology and radiology as detailed below;

- In line with the recovery plan pathology turnaround time for patients on a cancer pathway has seen significant improvement and is now in line with the target time. This has allowed patients diagnosis appointment to be moved to earlier in the pathway, and this will show impact in future months.
- The urology position has improved, although it required more improvement to allow us to deliver the standards.
- The radiology department has delivered the improvements and consistently meets the turnaround plan.

The focus of recovery has now moved to reducing the number of patients waiting more than 62 days. We set a trajectory to reduce the number to 46 by 31st March 2019 and achieved 47 (from a starting point of 73). This means that the percentage of patient treated within the target in March will be lower than the target. The overall aim is to reduce the number of patient waiting over 62 days to 37 and this would then mean we could consistently meet the cancer treatment target from March 2020.

Areas of concern are gynaecology and Endoscopy;

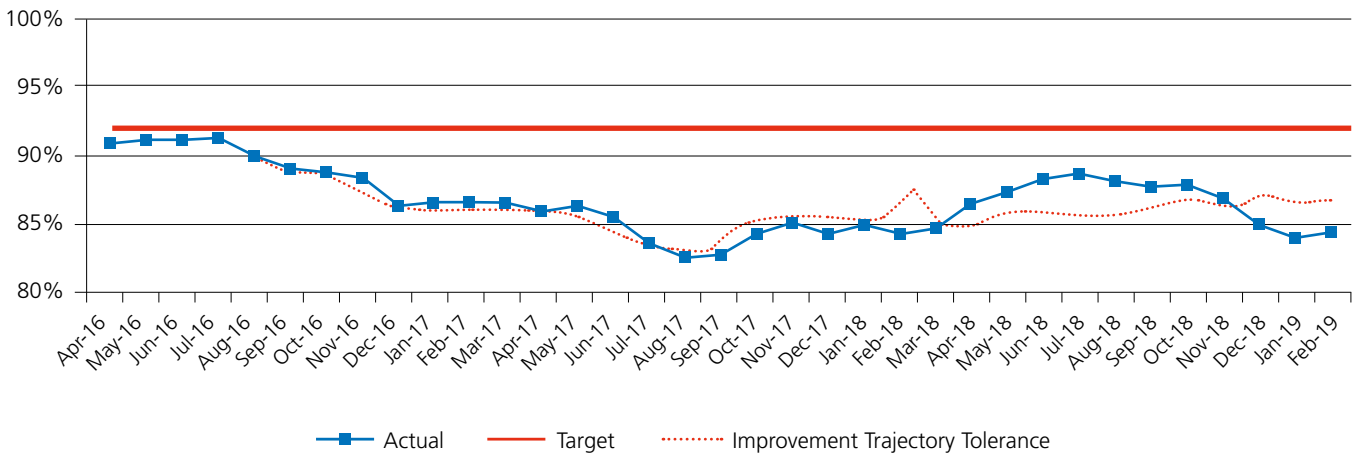
- Gynaecology has scheduled additional lists to address gaps in capacity. Job plans have been amended from 1st April 2019 to increase 2 week wait slots and joint work is underway with Basildon Hospital to improve the pathway.
- A recovery plan is currently being developed for endoscopy looking at both a short to medium term plan, and a longer term sustainability plan

Referral To Treatment (RTT) incompletes waiting time

Performance was below trajectory and plan for the year. The largest growth in patient tracking list (PTL) size are orthopaedics (924) mainly driven by increased referrals levels, urology (908) due to the switch of resources to manage the significant growth in referrals and treatments for cancer and gastroenterology (581) which is also impacting on capacity for endoscopy. The most significant reduction in PTL size is for ophthalmology (992) in line with the speciality recovery plan.

Plans for increasing the activity for orthopaedics and urology are being discussed with the Clinical Commissioning Group for the 2019/20 plan and a system wide plan is being agreed for gastroenterology including endoscopy.

Figure 18: Compliance with referral to treatment incomplete waiting times target - Local data source



4.3.2 Priorities for improvement 2019/20

The Chief Medical Officer for the MSB Group is the named Executive lead for quality improvement with the Site Director of Nursing taking local ownership for quality improvement and priorities for Southend Hospital. The focus on moving towards the merger of the three Trusts over the next few years has increased the emphasis for quality priorities to be more strategically focused across the MSB and aligned to the MSB ambition. The ambition is to create a financially sustainable modern health system that delivers excellence in local and specialist services, demonstrably improves the health and wellbeing of the local communities, and provides a vibrant place for staff to develop, innovate and build careers.

The three Trusts from the MSB group have worked together to develop a unified approach to quality improvement around 3 key domains of patient safety, patient experience and clinical effectiveness. The priorities are to deliver safe, effective, personal care, with a focus on zero tolerance to never events, the deteriorating patient including cardiac arrest and delivering clinical effectiveness through service reconfiguration.

The quality priorities below in table 39 are a combination of MSB agreed priorities and local priorities based on those relevant to Southend Hospital in addition to an explanation as to why previous priorities are no longer being included within the quality accounts.

MSB wide quality priorities

Never events – never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systematic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Our priority for 2019/20 is to focus on zero tolerance to never events.

Cardiac Arrest - Our priority for 2019-20 is to reduce inpatient cardiac arrests due to delay in recognition of patients at risk. We aim to ensure all patients are appropriately monitored using NEWS2 score and deteriorating patients are identified and escalated to allow timely interventions that can prevent cardiac arrest. We want to ensure appropriate discussions are had in a timely manner regarding resuscitation status, recognising when patients are approaching their last months of life with advanced care planning, acknowledging the wishes of patients and their carers.

Clinical Service Reconfiguration - Clinical service reconfiguration will be implemented over a number of phases with a bundle of services being implemented simultaneously during each phase. The priority for 2019/20 will be to deliver on the planned changes to services in bundle 1 which consists of the following changes; Urology, Vascular (phase 1 – emergency), Trauma and Orthopaedics (phase 1 – Braintree extension) and Interventional Radiology. It is proposed that these changes will go live in October 2019 depending on the outcome of the referral to the Secretary of State by Southend-on-Sea Borough Council and Thurrock Council.

In setting the future quality priorities, the 2018/19 priorities were reviewed to determine whether these should remain for the forthcoming year for Southend Hospital and were updated taking into consideration any emerging areas for improvements. Any quality priorities not included in the 2019/20 priorities are detailed below along with the reason:

- **Reduce mortality associated with sepsis** - this improvement was achieved in 2018/19.
- **Fully embed the ward accreditation programme** - a decision has not yet been made on the direction for this project hence this has not been included in the 2019/20 quality priorities.
- **Reduce in-hospital falls** – although the target was not quite met for 2018/19, this was a stretch target and the original target set in 2015/16 was met and has been sustained below the national average. Measuring and reducing falls is business as usual and monitored on a monthly basis therefore this priority has not been included in the 2019/20 quality priorities.
- **Patient flow capacity and demand priorities** – The trust has ongoing recovery plans in place to deliver against trajectories across the emergency and elective areas (ED 4 hour wait, RTT incomplete target, cancer 62 day waits). Delivery against the standards will be dependent on funding and support from the commissioners within the contract. Achievement against these standards is now business as usual, there are robust recovery plans in place and these indicators are reported in other sections of the quality report and annual accounts. Therefore, these priorities will not be included within this section of the quality report for 2019/20.

Table 39: Quality priorities 2019/20

Domain / improvement priority	Rational for inclusion	How will progress be measured	Executive Lead Monitoring Forum
Patient Safety: reducing avoidable harm events to our patients.			
MSB wide priority: Zero tolerance to never events	Never events are serious incidents that are entirely preventable and as such should never occur. We want to protect our patients from avoidable harm by ensuring we have safe systems and procedures in place to avoid never events from happening.	Never events are included within the monthly KPIs and are reported to Trust boards and committees and the clinical commissioning groups	Chief Nurse Quality Committee in common Clinical Quality Review Group
Reduce avoidable pressure ulcers by 30% from baseline of 0.21% of admissions to 0.15% by March 2020.	We want to aim to deliver harm free care for every patient every time and ensure patient's experience safe care. The rate of avoidable pressure ulcers increased in 2018/19 due to a change in the reporting and review processes which have improved the validity of the data. A new baseline has been set and target for improvement in 2019/20	Avoidable pressure ulcer data is included in the monthly performance reports which are reviewed at directorate and board level.	Director of Nursing Quality Committee in common and falls and pressure ulcer review panel.
Achieve safe staffing levels as indicated by the safe nursing care tool (SNCT) with permanent staff by March 2020	Adequate staffing levels are vital to ensure that the Trust can meet clinical demand whilst ensuring there are sufficient resources to support the improvement priorities. We want to continue to mitigate the risk through the workforce strategy and staff recruitment and retention plans.	Daily monitoring of staffing levels and patient acuity is in place to ensure that staffing levels are matched to meet the clinical needs of our patients to ensure their safe care. Staffing levels are monitored by the board quarterly	Director of Nursing Director of HR & OD

Domain / improvement priority	Rational for inclusion	How will progress be measured	Executive Lead Monitoring Forum
Clinical Effectiveness: improving patient outcomes			
MSB wide priority: Reduce cardiac arrests due to delay in recognition of patients at risk from baseline for inpatients across the MSB group	We want to continue to reduce avoidable cardiac arrests and ensure appropriate decisions are made in a timely manner regarding resuscitation status.	Cardiac arrest rates are monitored by the site leadership team weekly and by the Quality and Safety Committee and trust board quarterly. We want to continue to reduce avoidable cardiac arrests by 25% from baseline of 1.23 to 0.9 per 1000 admissions by March 2020. All cardiac arrests are reviewed in real time to identify and share any learning, including review of documentation and escalation of patients with high NEWS2 prior to their cardiac arrest.	Medical Director Resuscitation Committee/ Deteriorating Patient Group Mortality Surveillance Group Quality committee in common
MSB wide priority: To implement bundle 1 of the clinical service reconfiguration by 31 October 2019	As part of the Sustainability Transformation Programme, the three acute Trusts aim to deliver improved safety and reliability of services and improved access and outcomes for patients through reconfiguring clinical services.	Strategic Programme Board monitors the implementation of the clinical reconfiguration.	Chief Medical Officer Strategic Programme Board
Embed a consistent mortality review process through utilisation of the mortality review software (SMART) to ensure lessons learnt drive improvement	We recognise the need to continue to embed processes to identify and respond to deteriorating patients, together with ensuring patients approaching end of life and their families have an opportunity to voice preferences through discussion about appropriate ceilings of care.	• Confirmation of Medical Examiner review of all adult inpatient deaths; • structured mortality reviews meeting the requirement to complete a sample of 25% of all deaths including those mandatory categories; • cross site mortality panel review of cases where concerns in care reported • Mortality metrics monitored via local mortality groups • Audit of use of Treatment escalation plans and DNACPR forms	Medical Director Site Mortality surveillance group

Domain / improvement priority	Rational for inclusion	How will progress be measured	Executive Lead Monitoring Forum
Improving Patient Experience: Improving patient feedback and patient engagement			
We aim to improve the percentage of patients who would recommend the Trust to ≥95% for inpatients and ≥90% for Accident and Emergency patients by March 2020. This was not achieved in 2018/19 therefore remains a priority	In order to focus our improvement efforts in areas that are important to our patients, we need to first understand the experience our patients and their family or carers have.	The Friends and Family Test results are monitored on a monthly basis at ward / departmental and directorate level. The results are included in the monthly performance reports. Results are also monitored bi-monthly at the quality and safety committee and quarterly by the Board.	Director of Nursing Directorate performance meetings Quality Committee in common
We aim to improve our national inpatient survey score for the question regarding patients being involved in decisions about their care and treatment by 5 points to 77 (0 being the worse possible score and 100 being the best) by March 2020. This will bring us within the second quartile of reporting Trusts (currently in the third quartile). This was not achieved in 2018/19 therefore remains a priority	The patient engagement strategy supports the Trust strategy and determines how the Trust is committed to working in partnership with patients.	Results of the national inpatient survey are monitored by the quality and safety committee. Local surveys are carried out to measure the improvement during the year. In addition to this, patient engagement activities such as patient and carer focus groups will be reported to the Quality and Safety Committee.	Director of Nursing Quality Committee in common
We aim to ensure that we respond to 90% of all complaints in a timely manner as set out in our policy by March 2021	The Trust currently has a backlog of complaints and the CQC have issues a requirement notice in respect of the timeliness of complaint responses	Complaint response times are reported to the Clinical Governance Committee and included in weekly reports to Directorates and the Site Leadership team	Director of Nursing Quality Committee in common

4.3.3 Statement of assurance from the Board of Directors

These statements of assurance follow the statutory requirements for the presentation of quality accounts, as set out in the National Health Service (Quality Accounts) Regulations 2010.

Information on the NHS services provided

During 2018/19, Southend University Hospital NHS Foundation Trust provided and / or sub-contracted 51 relevant health services.

Southend University Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 51 of these relevant health services.

The income generated by the NHS services reviewed in 2018/19 represents 88% of the total income generated from the provision of NHS services by Southend University Hospital NHS Foundation Trust for 2018/19.

Participation in national clinical audits

During 2018/19, 58 national clinical audits (2017/18 – 48) and five national confidential enquiries (2017/18 – six) covered relevant health services that Southend University Hospital NHS Foundation Trust provides.

During that period, Southend University Hospital NHS Foundation Trust participated in 84% national clinical audits (2017/18 – 91%) and 100% national confidential enquiries (2017/18– 100%) which it was eligible to participate in. Reason for lack of non-participation was due to a lack of IT software and staffing resources.

The national clinical audits and national confidential enquiries that Southend University Hospital NHS Foundation Trust was **eligible** to participate in and participated in and for which data collection was completed during 2018/19, are listed in Table 40 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 40: Participation in national clinical audit

National Clinical Audits 2018/19	Participation	Cases submitted (%)
Adult Community Acquired Pneumonia	no	
BAUS Urology Audits - Stress Urinary Incontinence Audit	yes	Data collection still open
BAUS Urology Audits - Radical Prostatectomy Audit	yes	100%
BAUS Urology Audits - Cystectomy	yes	100%
BAUS Urology Audits - Nephrectomy audit	yes	100%
Cardiac Rhythm Management (CRM)	yes	100%
Case Mix Programme (CMP)	yes	100%
Elective Surgery (National PROMs Programme)	yes	100%
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service	no	
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	yes	100%
Feverish Children (care in emergency departments)	yes	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	no	
Learning Disability Mortality Review Programme (LeDeR)	yes	100% (9 Cases)

National Clinical Audits 2018/19	Participation	Cases submitted (%)
Major Trauma Audit	yes	71-84% (Jan to Nov 2018)
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal morbidity and mortality confidential enquiries (reports alternate years)	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports annually)	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance (reports annually)	yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	yes	78% (in progress)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Adult Asthma Secondary Care	yes	Data collection in progress
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation	yes	Data collection starts in March
National Audit of Breast Cancer in Older People (NABCOP)	yes	100%
National Audit of Cardiac Rehabilitation	yes	100%
National Audit of Care at the End of Life (NACEL)	yes	100%
National Audit of Dementia (in General Hospitals)	yes	100%
National Audit of Pulmonary Hypertension	no	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	yes	Data collection ongoing
National Bowel Cancer (NBOCA)	yes	100%
National Cardiac Arrest Audit (NCAA)	yes	100%
National Comparative Audit of Blood Transfusion programme Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	yes	Took part but had no qualifying cases
National Comparative Audit of Blood Transfusion programme Management of massive haemorrhage	yes	100% (5 Cases)

National Clinical Audits 2018/19	Participation	Cases submitted (%)
National Diabetes Audit - Adults National Diabetes Footcare Audit	no	
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDIA)	no	
National Diabetes Audit - Adults National Pregnancy in Diabetes Audit	yes	100%
National Diabetes Audit – Adults National Diabetes Core	no	
National Early Inflammatory Arthritis Audit (NEIAA)	yes	100%
National Emergency Laparotomy Audit (NELA)	yes	<100%
National Heart Failure Audit	yes	98%
National Joint Registry (NJR)	yes	100% (542 cases)
National Lung Cancer Audit (NLCA)	yes	100%
National Maternity and Perinatal Audit (NMPA)	yes	Data collection ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	yes	100%
National Oesophago-gastric Cancer (NOGCA)	yes	100%
National Ophthalmology Audit (NOD)	no	
National Paediatric Diabetes Audit (NPDA)	yes	100%
National Prostate Cancer Audit	yes	100%
National Vascular Registry	yes	Carotids (100%) AAA (100%) By-passes (100%) Major amputations (19%)
Non-Invasive Ventilation - Adults	no	
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic Consumption	yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antimicrobial Stewardship	yes	100%
Sentinel Stroke National Audit programme (SSNAP)	yes	Data collection in progress >90%

National Clinical Audits 2018/19	Participation	Cases submitted (%)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	yes	37 cases (100%)
Seven Day Hospital Services Self-Assessment Survey	yes	100%
Surgical Site Infection Surveillance Service	yes	100%
Vital Signs in Adults (care in emergency departments)	yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	yes	100%

There are nine national clinical audits that the Trust did not submit data to, mainly due to a lack of staff resources. The Trust did not take part in the national Ophthalmology audit due to incompatible software to enable case submission. There are three national clinical audits that we are still awaiting confirmation of participation.

Table 41: Participation in National Confidential Enquiries

National Confidential Enquires	Participation
Acute Heart Failure	Organisational questionnaire not provided Case note extracts not provided Clinician Questionnaires returned – 20%
Perioperative Diabetes	Organisation questionnaire – 100% Surgical questionnaires returned – 38% Anaesthetic questionnaires returned – 100% Case note extracts returned – 50%
Pulmonary Embolism	Organisational questionnaire – 100% Case note extracts – 100% Clinician Questionnaires returned – 100%
Acute Bowel Obstruction	Case note extracts – 100% Data collection ongoing
Long Term Ventilation	No qualifying cases

During 2018/19, a number of returns for both national clinical audits and national confidential enquires were below the expected number. Internal processes have been reviewed and escalation processes have been enhanced to identify any resource issues which can be mitigated to ensure that response rates increase.

Published national clinical audit reports

The reports of 15 national clinical audits (2017/18 – 31) were reviewed by Southend University Hospital NHS Foundation Trust in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided.

National Audit of Breast Cancer in Older Patients - The audit investigates whether the care received by older women with breast cancer is consistent with recommended practice for breast cancer management, as described by NICE guidelines. The results showed that the Trust performed worse that the national average for patients having contact with a clinical nurse specialist (CNS). In response to these findings the trust has appointed an additional lead clinical nurse specialist (CNS) and another CNS has been appointed to ensure that all provide all breast cancer patients are provided with a named with a named CNS.

National Ophthalmology Database - The audit is intended to quality assure NHS cataract surgical services for patients whose vision is adversely affected by cataracts to the point where they seek surgical intervention. Our patients are sent out to the community for surgery but community optometrists are unable to access the bespoke software required to upload data and so we cannot review data on these patients and submit it to the national audit at this time. Work continues with community teams and the national audit to provide a solution and enable our future participation.

National Maternity and Perinatal Audit - The overarching aim of the NMPA is to produce high-quality information about NHS maternity and neonatal services which can be used to benchmark against national standards and recommendations and to identify good practice and areas for improvement in the care of women and babies. Following the audit, we now run a Birth Choices Clinic for women who have had a previous caesarean section, to provide them with the opportunity for counselling with a midwife on the options for delivery, prior to seeing the Consultant.

MBRRACE-UK Perinatal Mortality Surveillance - This report provides information on extended perinatal deaths in the UK and Crown Dependencies arising from births during 2016. The aims are to collect, analyse and report national surveillance data and conduct national confidential enquiries in order to stimulate and evaluate improvements in health care for mothers and babies. Good practice was highlighted in antenatal care, delivery and baby's characteristics for stillbirths and delivery and baby's characteristics for neonatal deaths. We have an action plan in place address the national recommendations made following the study, which includes the review of each stillbirth, data completeness and working with NHS England to establish a national forum to agree benchmarks to monitor stillbirth and neonatal mortality rates.

MBRRACE-UK Saving Lives, Improving Mothers' Care - This report includes surveillance data on women who died during or up to one year after pregnancy between 2014 and 2016 in the UK. In addition, it also includes Confidential Enquiries into the care of women who died between 2014 and 2016 from mental health conditions, thrombosis and thromboembolism, malignancy and homicide, as well as morbidity Confidential Enquiries into the care of women with major obstetric haemorrhage. An action plan is in development to include improvements in overall care, improving care for women with a haemorrhage, mental health problems, or those from vulnerable groups.

National Neonatal Audit Programme - The audit assesses whether babies admitted to NNUs in Great Britain receive consistent high quality care in relation to the measures that are aligned to a set of professionally agreed guidelines and standards. Trust results were good for Retinopathy of prematurity (ROP) screening and mothers who deliver babies <30 weeks gestation are given magnesium sulphate in the 24 hours prior to delivery. Actions being taken include improvements to data quality and patient information, the promotion of breastfeeding in pre-term babies and minimising unnecessary separation of pre-term/term babies from their mother.

National Paediatric Diabetes Audit - The audit monitors the incidence and prevalence of all types of diabetes amongst children and young people receiving care from a paediatric diabetes unit in England and Wales. Whilst the trust's scores had improved in the majority of standards compared to our previous results, we were still below the national average. In response we have developed a robust action plan to provide assurance to our regulators and ensure the trust is not a negative outlier in future. This work included the timely uploading of data, blood pressure monitoring carried out at each clinic for 12 year olds, and urine screening to be carried on clinic visits for patients with type 1 diabetes mellitus age >12yrs.

The Learning Disabilities Mortality Review (LeDeR) - The LeDeR programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. This report produces national recommendations only but as a result of these we are strengthening our collaboration, information sharing and communication with different care providers and agencies. We are also aiming to introduce mandatory LD awareness training for staff and aim to share appropriately patients' health action plans with the relevant care agencies to help 'join up' care and inform service provision and development.

Intensive Care National Audit and Research Centre (ICNARC) - The Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units to compare outcomes, help units understand more about the care they deliver and aims to assist in decision-making, resource allocation and local quality improvement. The report showed that the trust's performance was 'as expected' or 'better than expected' in each quality indicator, which included discharges home, unit-acquired infections, delayed discharges to the ward and unplanned readmissions.

National Emergency Laparotomy Audit (NELA) – This is an ongoing clinical audit of adult patients having emergency bowel surgery. The trust's results were better than the national average in every indicator measured in the audit, except for patients over 70 years of age being assessed by a geriatrician prior to surgery. Although at an early stage, we have consulted with another local trust about their arrangements for meeting this standard. We have also improved joint working between the anaesthetic and surgery teams to ensure timely input of cases to the national audit and this has seen an improvement in the number of cases we have submitted and closed.

Falls and Fragility Fractures Audit Programme, Fracture Liaison Service Database – This is delivered as part of the Falls and Fragility Fracture Audit Programme (FFFAP), which aims to improve the delivery of care for patients who have falls or sustain fractures through effective measurement against standards, feedback to providers and quality improvement initiatives. We did not take part in the audit so our main priority is to ensure we participate next year. From the national recommendations we also aim implement actions to improve the detection of spinal fractures; improve the flow of appropriate patients to the fracture liaison service, and improve adherence to bone protection in the community.

National Bowel Cancer Audit Programme (NBOCAP) – The aim of the audit is to measure the quality of care and outcomes of patients with bowel cancer in England and Wales. The audit shows that we are a good performing unit with no concerns generated from the report. We have a very high rate of laparoscopic resections compared with national results and we have a high number of harvested lymph nodes. We have low adjusted 90-day mortality and low circumferential resection margin positivity.

National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) -This audit provides a 'yearly snapshot' of the organisation of paediatric epilepsy services for children and young people in England and Wales. The report has highlighted the need for trusts to have an epilepsy nurse specialist, and this will be used to formulate a business plan for the formation of the role. We have also initiated direct discussions with Great Ormond Street Hospital's neurology team to establish formal Epilepsy links.

National Audit of Dementia – Delirium Spotlight Audit - This audit examines aspects of care received by people with dementia in general hospitals in England and Wales. This spotlight audit on delirium has been carried out to look in more detail at an area where hospitals have seemed to be underperforming and to clarify inconsistencies in the data. In response to the audit findings, we have introduced a new care pathway for the recognition, assessment and management of delirium within the hospital. We have also made changes to the way our Dementia CQUIN team operates in order to co-ordinate care with the Dementia Intensive Support Team to ensure patients are followed up in the community.

National Audit of Care at the End of Life (NACEL) - The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in One Chance to Get It Right and NICE guidance. Although the trust's results were good and in line with national findings, we will continue to review practice and implement actions in response to the *Gosport War Memorial Hospital Inquiry.*

Local clinical audits

The local corporate clinical audit programme links with the Trust quality strategy and key organisational risks. The reports of 17 local clinical audits and quality improvement projects (2017/18 – 16) were reviewed by Southend University Hospital NHS Foundation Trust in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided.

Safeguarding Children

This audit into our compliance with the Children Act 2004 was undertaken to review whether our functions and services promoted the welfare of children. Our audits gave us substantial assurance that we have effective training in place but moderate assurance about the use of record-keeping systems in the emergency department and staff access to supervision. Actions are in place to educate staff on the correct processes to use when updating the records system and to explore how staff can best access supervision.

Record keeping

The aim of the audit is to improve the standard of healthcare record keeping in the Trust. Three audits were carried out this year but these gave us 'moderate assurance' that standards were being adhered to. To help improve these, we publish a 'Key messages' document following each audit that provides quick-reference tips for better entries in patients' records. We are reviewing this audit for 2019/20 and looking to implement a new audit that runs alongside the national Seven Day Services assurance process.

WHO safety checklist

The aim of the audit is to provide assurance that the WHO safety checklist is used across the Trust for all applicable surgical procedures. The audit continues to provide us with 'substantial assurance' that processes are in place. Peer auditing is undertaken across directorates and WHO compliance will continue to be audited and kept high profile. The audit will be expanded in 2019/20 to include procedures carried out in the outpatients department.

Patient transfer audit

The aim of the audit is to provide assurance that the risk assessment process for medical in-patient transfers (outlier moves) has been implemented effectively across the Trust. The audit demonstrated that transfers being made were supported by fully completed risk assessments and gave us 'substantial assurance'.

Safe Patient Flow Bundle (Consultant Review in <14 hours)

The aim of the audit is to provide assurance that patients are seen by a consultant within 14 hours of admission to the hospital. This is a new audit for 2018/19 that was agreed and is being implemented with neighbouring acute trusts in Basildon and Chelmsford. This is performed on a quarterly basis and provides 'moderate assurance'. Quality improvement work has been in place since last year to ensure accurate recording of the timing of consultant reviews and to develop and agree pathways for treatments that can be delegated to junior doctors.

Venous thromboembolism (VTE)

The aim of the VTE audit is to ensure that a VTE risk assessment is completed correctly within 24 hours for at least 95% of patients admitted for >24 hours and to ensure that the drugs and mechanical prophylaxis have been appropriately prescribed and administered. This is a new audit for 2018/19 that was agreed and is being implemented with neighbouring acute trusts in Basildon and Chelmsford. The current assurance level is 'moderate assurance' and the findings have been used to initiate quality improvement work, most notably, in care of the elderly and cancer services.

Consent in Paediatrics

The aim of the audit is to ensure that consent is taken for children and young people undergoing surgical and non-surgical procedures. The audit demonstrated that consent was being obtained and recorded appropriately and that staff were aware of Gillick Competences and Fraser Guidelines and applied these proportionately when obtaining consent from young people. However, an action plan is in place to improve the recording of consent in cases of non-surgical procedures, such as lumbar puncture.

Consent in Adults

The aim of the audit is to ensure that consent is taken properly for patients in surgery, endoscopy and cardiology. The audit provides 'moderate assurance'. To help improve standards we will publish a 'Key messages' document to give staff quick-reference tips for the correct completion of the consent form. We are also reviewing our consent training for doctors.

Preventing ill health by risky behaviours – alcohol and tobacco

The aim of this audit is to support people to change their behaviour to reduce the risk to their health from alcohol and tobacco. We re-designed our most frequently used admission pro format to include clear prompts and signposting and these were in circulation from April 2018. However, our findings for this audit have shown no improvement in assurance and we shall implement quality improvement work from quarter 1 of 2019/20.

Documentation of mental capacity and 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms

The aim of the audit is to provide assurance that doctors are documenting on the DNACPR forms when a patient lacks capacity to inform decision making on DNACPR. This is a new audit for 2018/19 that was agreed and is being implemented with neighbouring acute trusts in Basildon and Chelmsford. Despite a positive start, overall, the audit has provided us with 'moderate assurance' that a patient's mental capacity assessment was being completed for patients who were deemed to lack capacity. Where any improvements are required, reminders of the required standards are sent out to the staff concerned by the lead clinician.

Discharge – Readmission with 48 hours

This audit was performed to look at readmissions to the hospital to see if they were avoidable and help contribute to the landscape of avoidable readmissions. It was found that the notes were often hard to navigate with multiple incomplete forms found. The results were fed back to the mortality Surveillance Group and quality improvement work considered to improve compliance.

End of Life Care – Syringe Pump Audit

The aim of the audit is to measure our current practice against NICE guidelines for the care of dying adults in the last days of life. The audit revealed that there is still a delay commencing a pump after it has been prescribed. Actions are being implemented to educate staff on the electronic prescribing system and doses of anticipatory injectable medications, and improved reporting when a pump is not commenced within one hour.

Accessible Information Standard (AIS)

The aim of the audit is to assess compliance with the AIS, in particular, that patients are prompted to identify that they have a communication support need so that they can receive information in their desired format. For the second audit running, results showed that whilst we performed very well at asking patients about their communication needs, we need to improve on sharing this information, recording that the patient's needs have been met and highlighting their needs on our electronic records system so that other teams are made aware of the person's needs. An action plan is being developed to address these points. We continue to improve the use of communication aids for both inpatients and outpatients including the use of hearing loops, picture boards and communication cards.

Improving services for people with mental health needs who present to A&E (CQUIN)

The aim of the audit is to ensure that attendances to A&E are properly coded to facilitate the identification of patients that might benefit from psychosocial interventions, and the sharing of data between relevant care providers. The audit provided 'substantial assurance' that attendances were being properly coded. Mental health services are available from Essex Partnership University Trust within the mental health suite located in the Emergency Department. The suite is staffed to care for up to 3 mental health patients at any one time and provides mental health liaison assessment and referral.

Follow up of diagnostic tests

The aim of the audit is to assess ourselves against the trust's diagnostic testing policy in respect of accurate and timely reporting of diagnostic test results. The audit provided 'substantial assurance' (100 per cent) that results were handled appropriately and reported to the correct person within the prescribed timescales.

LocSSIPs – Local Safety Standards for Invasive Procedures

The aim of this audit is to monitor compliance with the LocSSIPs in the areas where they are used. This was focused in outpatient services. This audit provided 'substantial assurance'. However, it led to a revision of the written procedure to better reflect the nature of treatment delivery in an outpatient setting. In particular, that the procedures are conducted while the patient is awake.

Patient-led assessments of the care environment (PLACE)

The last annual PLACE audit at the trust was undertaken in May 2018. Ten wards, six clinics, the Emergency department and communal areas were assessed and five mealtime services observed. Whilst the scores showed slight improvement for cleanliness, dementia-friendly environment and food, actions were required for condition, appearance and maintenance; privacy, dignity and wellbeing and disability. An action plan has been commenced to address issues identified during the assessment. As part of our drive to provide safety, quality assurance of our care environment and subsequent patient experience, a more frequent programme of care environment assessments (in line with PLACE) is being developed across MSB to commence in 2019/20.

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Southend University Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1,216 (2017/18 – 1,703). There was a reduction in the number of patients recruited during the year due to the closure of particular studies in 2017/18 that were high recruiting and easy to recruit to studies.

The research and development department team of 22 staff are funded by the clinical research network (CRN) and surplus commercial income. Southend University Hospital NHS Foundation Trust received £803,545 (£1,067,501 2017/18) from the CRN: North Thames NIHR Network and a further £20,800 performance award (£20,000 2017/18) was received directly from the Department of Health. The Trust is a partner in the NIHR North Thames Clinical Research Network and is working closely with their senior team to ensure smooth running of R&D services.

50% of new studies (2017/18 45%) recruited the first patient within 30 days and a recent internal audit revealed a high level of compliance with all the required standards and all projects were successfully externally inspected.

336 primary research articles (334 2017/18) were published in peer-reviewed journals during 2017/18 and Southend University Hospital NHS Foundation Trust has the second highest score in Essex for research publications as assessed by ResearchGate.

Information on the use of the CQUIN framework

A proportion of Southend University Hospital NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Southend University Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The Trust's main contract for 2018/19 is a block contract which includes a condition of guaranteed full payment for CQUIN. Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically on the NHS England website at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

The amount of income received by Southend University Hospital NHS Foundation Trust in 2018/19 that was related to quality improvement and innovation goals is estimated to be £5.8m (£6m 2017/18), of which £5.3m (£5.4m 2017/18) is guaranteed via the block contract arrangement.

Information relating to the registration with the Care Quality Commission and periodic/ special reviews

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.

Southend University Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

Southend University Hospital is registered to carry out the following services:

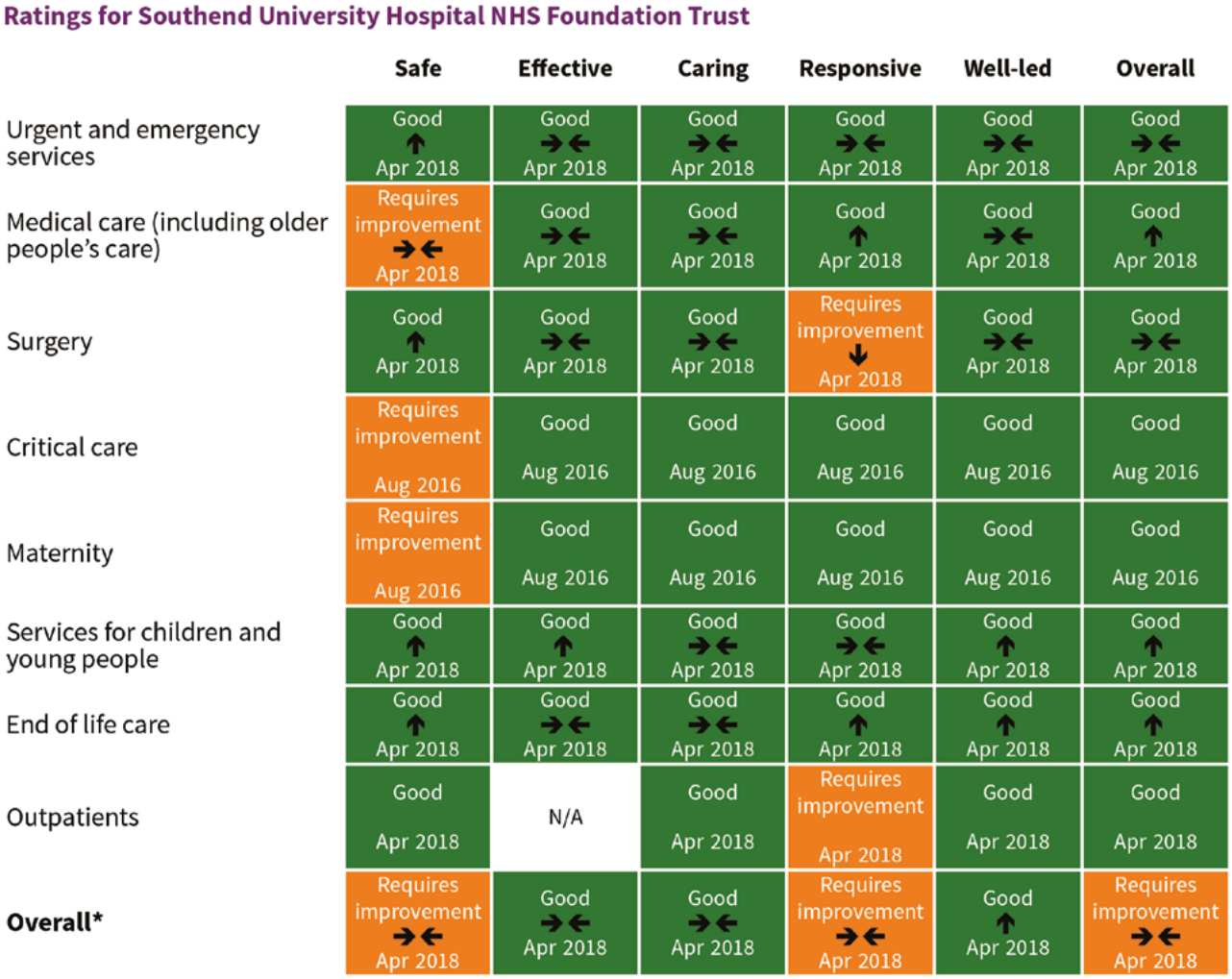
- Treatment of disease, disorder or injury.
- Surgical procedures.
- Diagnostic screening procedures.
- Maternity and midwifery services.
- Termination of pregnancies.
- Family planning services.
- Assessment or medical treatment for persons detained under the 1983 Act.
- Management of supply of blood and blood derived products.

The Care Quality Commission has not taken enforcement action against Southend University Hospital NHS Foundation Trust during 2018/19.

The Trust is subject to periodic reviews by the CQC and Southend University Hospital NHS Foundation has not participated in any special reviews or investigations by the CQC during the reporting period.

In April 2018 the CQC published a report of the comprehensive inspection it carried out of Southend University Hospital NHS Foundation Trust in November and December 2017. The Trust is currently rated as 'requires improvement' (see Figure 19) with overall 'Good' ratings across all core services and with a rating of 'Good' for the 'Well Led' domain. The Trust continues to work on the areas for improvement highlighted in the report though the 'Maintaining High Standards' programme.

Figure 19 – Data source- Care Quality Commission



Ratings for Southend University Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Medical care (including older people's care)	Requires improvement →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018
Surgery	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Critical care	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Services for children and young people	Good ↑ Apr 2018	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018
End of life care	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018
Outpatients	Good Apr 2018	N/A	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Overall*	Requires improvement →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Good ↑ Apr 2018	Requires improvement →← Apr 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Three requirement notices were issued by the CQC following publication of the report in April 2018 and the Trust has taken and is taking the following actions to address these;

Regulation 12 HSCA (RA) regulations 2014 Safe care and treatment

- The trust has a process in place to ensure that children being looked after in the emergency department are cared for by nursing staff with the appropriate skills and competencies
- Security arrangements in the children's ED are improved to ensure children are kept safe.
- Adjustments to the environment within the mental health suite have been completed to ensure the safety of patients in this area.

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- The trust continues to improve nurse staffing levels and is one of our quality priorities.

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

- The action plan in relation to complaints management continues to be implemented and the timeliness of complaints is reviewed on a weekly basis and actions taken to address any issues.

Southend University Hospital NHS Foundation Trust has participated in one outlier alert investigation by the Care Quality Commission relating to the following area during 2018/19.

- Dr Foster mortality outlier alert for therapeutic endoscopic procedures on upper GI tract

Southend University Hospital NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- Improvements in health and safety and environment with the endoscopy unit
- Ensure appropriate equipment is available
- Review clinical pathways and processes
- Ensure staff have the appropriate skills and competencies
- Work towards achieving the Joint Advisory Group (JAG) accreditation

Information on the quality of data

Southend University Hospital NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

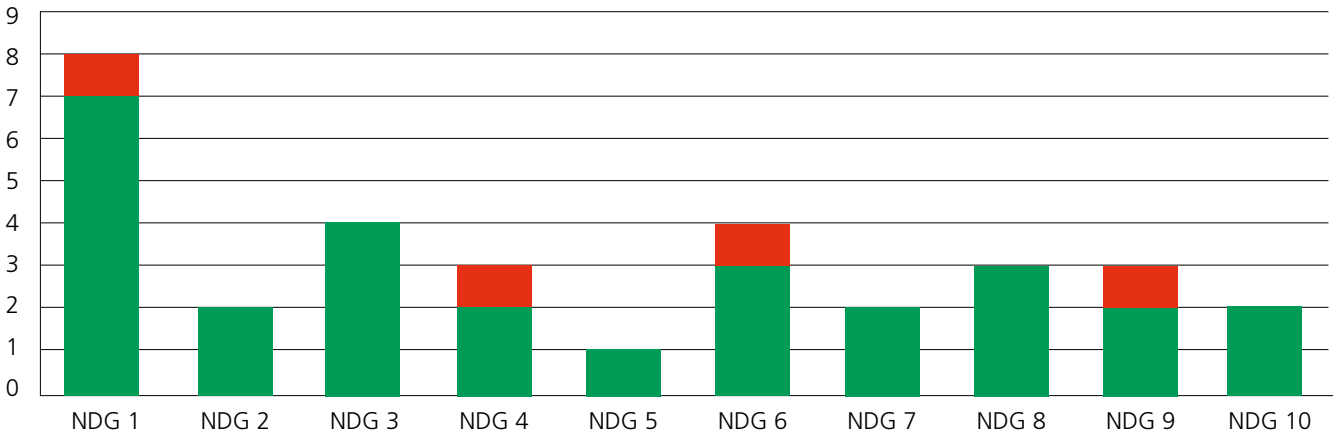
The percentage of records in the published data

- which included the patient's valid NHS number was:
    - 99.9% for admitted patient care (2017/18 – 99.8%).
    - 100% for out-patient care (2017/18 - 99.9%).
    - 99.3% for accident and emergency care (2017/18 – 99%).
- which included the patient's valid General Medication Practice Code was:
    - 100% for admitted patient care (2017/18 – 100%).
    - 100% for out-patient care (2017/18 – 100%).
    - 100% for accident and emergency care (2017/18 – 100%).

Information quality and records management

Southend University Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 96% (a total of 96 of 100 mandatory evidence items were provided for the Data Security and Protection Toolkit submission) and was graded 'not met' (2017/18 not satisfactory). An improvement plan, approved by the Senior Information Risk Owner, was submitted to NHS Digital outlining steps the Trust will take to ensure it meets the remaining mandatory standards within the next six months.

Figure 20: Information Governance level of compliance



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NOG 4 - Managing Data Access
NDG 5 - Process Reviews
NOG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 9 - IT Protection
NOG 8 - Unsupported Systems
NDG 10 - Accountable Suppliers
Met
Not Met

Data source: Local data

Payment by results

Southend University Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Improvement in data quality

Clinical Coding is the translation of medical terminology written by clinicians to describe the patient's diagnosis and treatment into nationally standardised codes. This information is vital to support the delivery, planning and monitoring of patient care services, the planning and management of Trust's services and the collection of income.

Southend University Hospital NHS Foundation Trust will be taking / has taken the following actions to improve data quality:

- The successful implementation of a shared training programme for clinical coding between Southend Hospital, Mid Essex Hospital and Basildon Hospital
- Continued involvement with clinicians in requesting guidance and clarity on coding issues
- Ongoing validation of coded sepsis data by a dedicated sepsis nurse
- The implementation of validation of coded AKI data by a dedicated AKI nurse
- A presentation on coding to junior doctors during induction
- The development of a senior coder to an approved Apprentice Clinical Coding Trainer after successfully completing and passing the trainer programme which will give support and guidance to trainee clinical coders and ensure all coders are offered professional coding support and guidance
- Continued development of strong networking links between Mid Essex and Basildon to support and share information and ideas

4.3.4 Reporting against core indicators

As set out in the NHS detailed requirements for quality reports 2018/19, NHS Foundation Trusts are required to report performance against a core set of indicators using data made available by NHS Digital. NHS foundation trusts are only required to report on indicators that are relevant to the services that they provide or subcontract in the reporting period. Where possible has been compared to the national average, lowest scoring trust and highest scoring trust.

Summary hospital mortality index (SHMI) and learning from deaths

The SHMI reports on Trust level mortality using a standardised methodology to calculate the ratio between the actual number of deaths following hospitalisation at the Trust against the expected number of deaths.

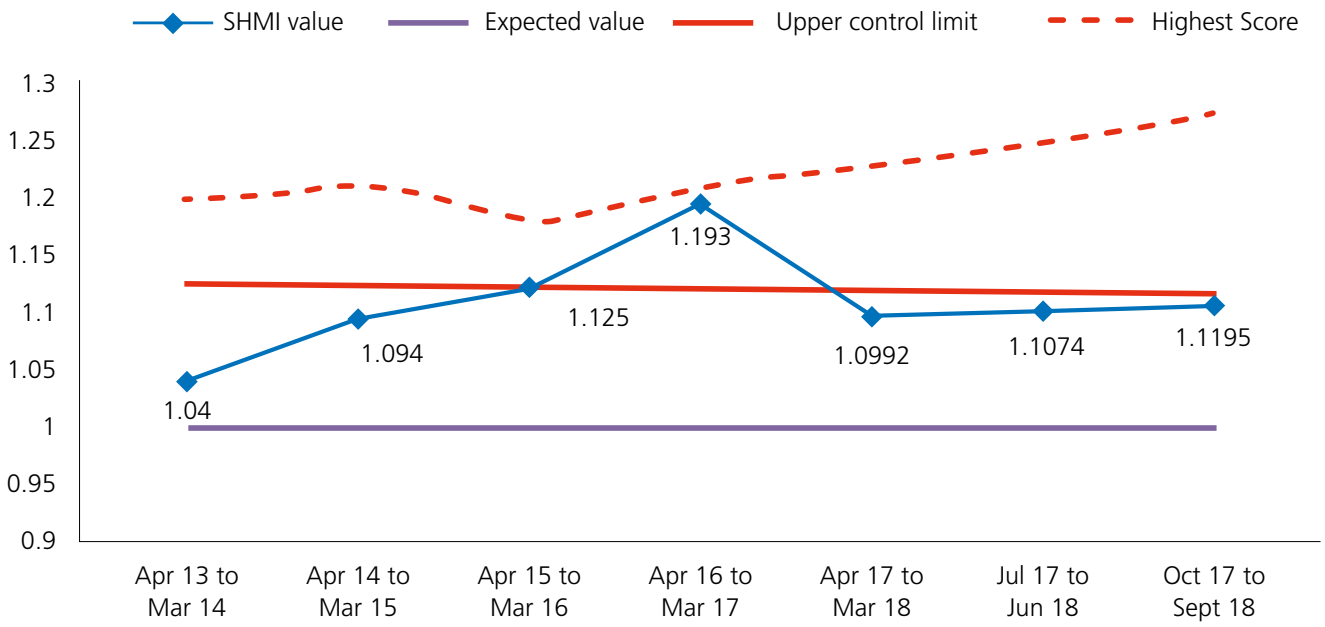
The latest SHMI value published in February 2019 for reporting period October 2017 to September 2018 is 1.1195 and our banding is 2 (range is from 1 to 3 with 3 being the best). This has increased slightly from the previous period ending June 2018 when it was 1.1074; however it does remain in within expected limits (0.89-1.12). The table and charts below shows the latest SHMI results for Southend University Hospital NHS Foundation Trust compared to all other Trusts (rank) and the highest and lowest scores.

Table 42: SHMI for Southend University Hospital NHS Foundation Trust

Period	Value	Expected (national)	Banding	Rank	Worst	Best
01/10/2017 to 30/09/2018	**1.1195**	1.000	**2 - Within expected**	114/131	0.6917	1.2681
01/07/2017 to 30/06/2018	**1.1074**	1.000	**2 - Within expected**	111/131	0.6982	1.2572
01/04/2017 to 31/03/2018	**1.0992**	1.000	**2 - Within expected**	110/131	0.6994	1.2321
01/04/2016 to 30/03/2017	**1.193**	1.000	**1 – higher than expected**	133/135	0.707	1.212
01/04/2015 to 31/03/2016	**1.125**	1.000	**1 – higher than expected**	125/136	0.678	1.178
01/04/2014 to 31/03/2015	**1.094**	1.000	**2 - Within expected**	119/137	0.670	1.210
01/04/2013 to 31/03/2014	**1.040**	1.000	**2 - Within expected**	92/141	0.539	1.197

Data source: NHS Digital

Figure 21: SHMI for Southend University Hospital NHS Foundation Trust for period April 2013 to September 2018



Data source: NHS Digital

Table 43: The latest percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust from 1 July 2017 to 30 June 2018 is 29.3%

Period	Trust result	National average	National lowest	National highest
01/10/2017 to 30/09/2018	**29.9%**	33.6%	14.3%	59.5%
31/07/2017 to 30/06/2018	**29.3%**	33.1%	13.4%	58.7%
01/04/2017 to 31/03/2018	**27.9%**	32.5%	12.6%	59.0%
01/04/2016 to 31/03/2017	**23.6%**	30.7%	11.1%	56.9%
01/04/2015 to 31/03/2016	**24.5%**	28.5%	0.6%	54.6%
01/04/2014 to 31/03/2015	**22.5%**	27.6%	0.2%	54.7%
01/01/2014 to 31/12/2014	**20.8%**	26.6%	0.2%	53.5%

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

In striving to understand our in-hospital mortality, the trust has continued our commitment to embed the National Quality Board learning from death recommendations, embed the medical examiner structure, and embed Structured Judgement review following RCP National Mortality Case Record review programme recommendations. These activities, although introduced in the previous reporting period, have been embraced in this reporting period and are driving quality improvement initiatives across the trust.

Learning from deaths

During 2018/19, 1,560 of Southend University Hospital NHS Foundation Trust patients died whilst in our care. This comprised the following number of deaths which occurred in each quarter for that reporting period:

- 379 in the first quarter.
- 363 in the second quarter.
- 373 in the third quarter.
- 445 in the fourth quarter.

The trust published its Learning from Deaths policy in September 2017. In this policy, the trust has defined 'in our care' for the 2018/2019 period as: a patient who dies whilst they are an inpatient. This definition does not currently extend to patients who have died during the 30 days after discharge.

During 2018/19, of the 1,560 of patients who died whilst an inpatient at Southend University Hospital NHS Foundation Trust:

- 3 were neonatal deaths, comprising of:
    - 1 In the first quarter
    - 1 In the second quarter
    - 0 In the third quarter
    - 1 In the fourth quarter
- 9 were still births, comprising of:
    - 1 In the first quarter
    - 4 In the second quarter
    - 2 In the third quarter
    - 2 In the fourth quarter
- 12 were people with learning disabilities or Autism, comprising of:
    - 3 In the first quarter
    - 5 In the second quarter
    - 1 In the third quarter
    - 3 In the fourth quarter
- 0 were identified as having a severe mental illness.

On 1st May 2018, Southend University Hospital NHS Foundation Trust launched the Medical Examiner model. The Medical Examiners role at Southend University Hospital NHS Foundation Trust is to provide robust, transparent and independent scrutiny of the medical circumstances and cause of death for our inpatients as well as ensuring the most appropriate deaths are reported to the coroner.

During 2018/19, 1,461 of Southend University Hospital NHS Foundation Trust patient deaths were scrutinised by a medical examiner, representing 94% of all deaths in our care. This comprised the following number of which occurred in each quarter for that reporting period:

- 341 in the first quarter, representing 90% of total number who died
- 344 in the second quarter, representing 95% of total number who died
- 359 in the third quarter, representing 96% of total number who died
- 417 in the fourth quarter, representing 92% of total number who died

By 29th April 2019, 503 mortality case record reviews and 5 serious incident investigations have been carried out in relation to the 1560 deaths included above.

In 5 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 159 in the first quarter
- 131 in the second quarter
- 114 in the third quarter
- 99 in the fourth quarter

4 representing 0.25% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing 0.26% for the first quarter
- 1 representing 0.28% for the second quarter
- 2 representing 0.54% for the third quarter
- 0 for the fourth quarter

These numbers have been estimated as a product of a multi-stage mortality review process. The trust uses the Royal College of Physicians (RCP) National Mortality Case Record Review (NMCRR) Structured Judgement Review (SJR) methodology to review death and escalates any 'poor' or 'very poor' care for a second stage, Multi-disciplinary Team (MDT) panel review. This MDT panel decides if there has been sufficient reason to believe that the death of the patient is more likely than not to have been due to problems in the care provided to the patient by the trust. It is the deaths that have been judged at this panel as more likely than not to have been due to problems in the care provided to the patient by the trust that are included in the number above.

Since the beginning of 2018/2019 Southend University Hospital NHS Foundation Trust has made huge strides in understanding and improving in-hospital mortality which is evident in the improvement in the trusts 2018/2019 Standardised Hospital Mortality indicator which is now within expected range. More information in this improvement can be found in table 42.

In striving to understand our in-hospital mortality, the trust has continued our commitment to embed the National Quality Board learning from death recommendations, embed the medical examiner structure, and embed Structured Judgement review following RCP National Mortality Case Record review programme recommendations. These activities, although introduced in the previous reporting period, have been embraced in this reporting period and are driving quality improvement initiatives across the trust.

In April 2018 of this reporting period the trust opened a new medical High dependency unit. Lessons learned from mortality review recognised that the trust did not have enough level 2 beds in which enhanced medical and nursing care could be provided. The impact was that patients with high acuity were either being treated on general wards supported remotely by the critical care outreach team, or being admitted to intensive care inappropriately. In April 2018 the Kitty Hubbard high dependency ward opened and allowed specialists to provide a high level of state of the art care for patients who require intensive monitoring and treatment.

Also in April 2018 of this reporting period the Hospital Out Of Hours Team reached full establishment. Although the Hospital Out Of Hours service was established in April 2017 of the previous reporting period it was in this 2018/2019 reporting period that the benefits have been realised for improving safety and mortality.

The Hospital Out Of Hours team, which is staffed out of hours 7 days a week by highly experienced, senior nurses, has greatly impacted the safety of the hospital at night and weekends. Using the e-observation system NERVECENTRE, the team can ensure there is clinical oversight of the hospital and by using the task management system, can ensure that there is joined up working with all out of hours and on call staff. The senior nursing team provide clinical, expert support to the foundation year doctors to ensure that the most appropriate member of the out of hours, multidisciplinary team, is assigned to a task. Enhanced deteriorating patient pathways using the national early warning system (NEWS) ensures that patients who become unwell are immediately flagged to the most appropriate team and receive swift review and treatment.

During this reporting period the trust has also seen huge improvements in the recognition, treatment and mortality of patients who have sepsis which is reported fully in section 4.3.1 of the quality report.

The next steps for Southend University Hospital include expanding the Hospital Out Of Hours team, extending the role of these senior nurses to increase the tasks that can be completed by non-medical members. This includes specialist skills such as non-medical prescribing, training to complete treatment escalation plans and DNACRP (Do not attempt cardio pulmonary resuscitation) forms, and also confirming death of a patient, all with the further aim of releasing the time of the on call foundation year doctors to see, review and treat sick and acutely unwell patients.

For 2019/2020 the trust aims to introduce NEWS2, continue to improve the recognition and treatment of acute kidney injury and work with our community partners to understand factors which affect out of hospital mortality.

Learning from deaths from the previous reporting period

At Southend University Hospital NHS Foundation Trust in 2017/2018 26 case record reviews and investigations were completed after the 23rd April 2018, which was the date of writing the 2017/2018 report, which related to deaths which took place before the start of the 2018/2019 reporting period.

0 of these deaths, representing 0% of the patient deaths before the 2018/2019 reporting period, have been judged to be more likely than not to have been due to problems in the care provided to the patient. This has been estimated using the previously recognised RCP NMCRR methodology whereby the reviewers were required to score a death as having a more than 50% chance of having been due to problems in health care. Deaths which were scored as a having a greater than strong evidence of avoidability and therefore investigated under the serious incidence framework have been included in the numbers above.

Thus a revised estimate of the deaths during the 2017/2018 reporting period for Southend University Hospital NHS Foundation Trust that were judged to be more likely than not to have been due to problems in the care provided to the patient has not changed from the number reported in 2017/18.

Patient reported outcome measures (PROMS)

PROMs measure the health gain in patients undergoing hip replacement, knee replacement, varicose vein or groin hernia surgery in England. The measure is based on the responses to patient questionnaires before and after surgery. The tables below show the final results for 2015/16 and 2016/17 and provisional results for 2017/18.

Table 44: Hip replacement Primary PROMs

Publication date	Period	Measure	Value	National Average	National Lowest	National Highest
Feb 2019 (Provisional Data)	01/04/18 To 30/09/18	EQ-VAS	Too few cases	15.57	7.644	21.943
		EQ-5D Index	Too few cases	0.48	0.406	0.564
		Oxford hip score	Too few cases	23.29	19.516	26.215
Aug 2018 (Provisional data)	01/04/17 To 31/03/18	EQ-VAS	12.566	13.87	7.013	20.763
		EQ-5D Index	0.46	0.47	0.398	0.581
		Oxford hip score	20.161	22.60	19.176	26.642
Aug 2018	01/04/16 To 31/03/17	EQ-VAS	12.4	13.4	8.55	20.177
		EQ-5D Index	0.428	0.445	0.31	0.537
		Oxford hip score	21.004	21.8	16.428	25.123
Aug 2017	01/04/15 To 31/03/16	EQ-VAS	10.958	12.386	4.945	18.704
		EQ-5D Index	0.416	0.438	0.320	0.512
		Oxford hip score	21.602	21.604	16.885	24.756

Data source: NHS Digital

Table 45: Knee Replacement Primary PROMs

Publication date	Period	Measure	Value	National Average	Worst	Best
Feb 2019 (Provisional Data)	01/04/18 To 30/09/18	EQ-VAS	Too few cases	8.226	1.935	12.887
		EQ-5D Index	Too few cases	0.35	0.266	0.426
		Oxford knee score	Too few cases	17.582	14.668	20.68
Aug 2018 (Provisional data	01/04/17 To 31/03/18	EQ-VAS	9.896	8.07	1.593	14.942
		EQ-5D Index	0.405	0.34	0.217	0.425
		Oxford knee score	18.918	17.135	12.365	20.82
Aug 2018	01/04/16 To 31/03/17	EQ-VAS	8.849	7.016	1.043	14.911
		EQ-5D Index	0.339	0.325	0.242	0.404
		Oxford knee score	16.546	16.258	12.335	19.884
Aug 2017	01/04/15 To 31/03/16	EQ-VAS	6.174	6.226	1.774	12.628
		EQ-5D Index	0.359	0.320	0.198	0.398
		Oxford knee score	17.421	16.365	11.956	19.971
Aug 2016	01/04/14 to 31/03/15	EQ-VAS	6.388	5.761	1.132	15.406
		EQ-5D Index	0.291	0.315	0.204	0.418
		Oxford knee score	14.913	16.116	11.430	19.581

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers the outcome scores are as described for the following reasons:

- Winter pressures in the trust have meant that too few operations were conducted for PROMs to commentate on since the last release of data.

Southend University Hospital NHS Foundation Trust intends to take the following actions to improve these outcome scores, and so the quality of its services, by:

- Outcomes are monitored and discussed within the departmental governance meetings and any drops in outcome measures analysed to find any reversible causes.

Readmission rates

Table 46 shows percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Table 46: Readmissions rate

Year	0-15	16+	Total
2014/15	5.01%	8.46%	8.08%
2015/16	4.85%	7.23 %	6.97%
2016/17	4.96%	7.32%	7.07%
2017/18	4.77%	7.98%	7.63%
2018/19	5.21%	7.39%	7.18%

Data source: local data.

Southend University Hospital NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its service, by:

- Weekly reports detailing re-admitted patients currently within the hospital are reviewed by the discharge team to investigate reasons for re-admission and ascertain if this outcome could have been avoided.
- Director of Operations for Emergency and Unplanned Care has requested a monthly 'frequent flyer' report to establish whether there is any co-relationship between frequent attenders to A&E and readmission rates.
- A clinical audit of re-admissions within 48 hours was carried out during in February 2018. This audit focused on establishing whether a link existed between re-admission and increased risk of mortality. The audit, undertaken by a local GP, was restricted to a random selection of 25 sets of case-notes. The outcome of the audit was inconclusive and as such a repeat audit focussing on primary reason for re-admission to hospital will be undertaken in Q1 2019/20.

Trust responsiveness to inpatient personal needs

This indicator is a composite, calculated as the average of five survey questions from the National Inpatient Survey:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you know to contact if you were worried about your condition or treatment after you left hospital?

Table 47: Composite measure from National Inpatient Survey

Period	Value	Expected (national)	Rank	National Lowest	National Highest
2017/18	**67.3**	68.6	81/148	60.5	85.0
2016-17	**64.8**	68.1	121/149	60.0	85.2
2015-16	**67.4**	69.6	107/149	58.9	86.2
2014-15	**66.8**	68.9	104/155	59.1	86.1
2013-14	**68.3**	68.7	74/156	54.4	84.2

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is taken from the national inpatient survey. Responses are collected using an independent approved contractor and the data is analysed by the Picker Institute on behalf of the Care Quality Commission.

Southend University Hospital NHS Foundation Trust intends to take the following actions to improve this data and so the quality of its services by:

- Our priority is to encourage more feedback from our patients using bespoke surveys and via our schedule of mock CQC inspections which includes asking patients about their experience and act on this feedback to improve patient experience.

Staff Friends and Family Test (SFFT)

The Staff Friends and Family Test is a measure of the percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their friends or family. The score is taken from the national staff survey carried out in all NHS Trusts.

Table 48: Staff Friends and Family Test data

Period	Trust value	Average All Acute Trusts	Rank	National Lowest	National Highest
2018	**68%**	70%	55/89	41	87
2017	**61%**	70%	75/93	47	86
2016	**64%**	70%	75/98	49	85
2015	**62%**	69%	75/99	46	85
2014	**61%**	67%	86/138	38	89

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers this percentage is as described for the following reasons:

- An external contractor (Quality Health) is contracted to gather and analyse the data on behalf of the Trust and this information is published nationally via the NHS Staff Survey internet site.
- Throughout the year there were a number of surveys taken, ranging from pulse surveys in specific directorates to a group wide bullying and harassment survey that also incorporated staff friends and family questions.

The SFFT is a mandatory activity and response rates have been low and currently the Trust uses the annual Staff Survey to drive action. There is a view that the hospital suffers from survey fatigue which may suggest the low response rate. The 2018 NHS staff survey was undertaken across the group, launched in October 2018 with the full results published in February 2019.

Southend University Hospital NHS Foundation Trust intends to take the following actions to improve these results, and so the quality of its services, by:

The development of a Staff Survey Action Plan to address the key issues highlighted in the 2018 NHS Staff Survey. This plan has and will inform current and future change programmes and actions within the Trust. There are 6 areas of concern; Improving communication; Dignity and respect; Staffing levels (attract and recruit); Leadership and management development; Staff health and well-being; Staff retention, recognition and engagement. The Staff Survey Action Plan forms the basis of the directorate action plans which will ensure the appropriate focus, resource and support can be given to these and that these translate into visible changes that make a difference to staff and patient care. Each directorate will be accountable for the development and delivery of their action plans and will also take actions forward for any significant areas of concern i.e. where there are adverse variations in scores against acute trust average unique to that area. Directorate Action Plans now also have MSB/Trust action sections to align to Group goals.

The communication action plan will be implemented to develop an open, honest and transparent relationship between staff and leadership. This includes publication of the Staff Survey Action Plan; engaging with our workforce via a Staff Survey Implementation and communication plan; Implementing a Task & Finish group to ensure the commitment to 'you said we did' is fulfilled; Developing a Staff Survey group brand aligned to the NHS Staff Survey branding; Creation of a Staff Survey intranet hub providing access to Staff Survey results, the published action plan, VLOG and BLOG updates, dates for engagement events, progress so far and good news stories; Promotion of and utilisation of a central email address 'yousaidwedid@' to encourage staff feedback and participation.

Progress against the Action Plan will be monitored via the Site Leadership team and with oversight by the Workforce Committee. Accountability for delivery at Directorate level will be via regular monitoring of Directorate plans by HR Business Partners, reporting to the Site Leadership team.

In preparation for the 2019 Staff Survey the development of a solid campaign will be aimed at securing a 60% response rate. KPI targets will be set for 2019 Staff Survey aiming to meet or exceed the NHS acute trust average in the themes which are below the acute trust average.

Venous thromboembolism risk assessment

Reducing avoidable death from venous thromboembolism (VTE) is an NHS patient safety initiative. It is nationally recognised that completing and acting upon a VTE risk assessment significantly reduces the risk of a patient developing a hospital acquired VTE. All patients who are admitted to hospital are required to have this VTE risk assessment completed and compliance with this is monitored both locally through the VTE committee and nationally via NHS England.

Table 49: VTE risk assessments for patients admitted to hospital

Period	Trust value	National Average	Rank	National Lowest	National Highest
Q4 2017/18	**98.68%**	95.2%	16/156	67.0%	100%
Q3 2017/18	**98.63%**	95.4%	15/154	76.1%	100%
Q2 2017/18	**98.4%**	95.2%	23/155	71.9%	100%
Q1 2017/18	**98.8%**	95.2%	20/156	51.4%	100%
Q4 2016/17	**98.5%**	95.5%	24/156	63.0%	100%
Q3 2016/17	**98.2%**	95.6%	29/157	76.5%	100%
Q2 2016/17	**98.4%**	95.5%	30/157	72.1%	100%
Q1 2016/17	**98.5%**	95.7%	26/157	80.6%	100%

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers that this percentage is as described for the following reasons:

- VTE risk assessment data is captured almost entirely electronically via the electronic prescribing system JAC. The risk assessment must be completed on the system before any medications can be prescribed and thus has helped to improve our compliance since this was introduced in 2015/16. There are a few areas which are not on the electronic prescribing system and hence use paper VTE risk assessment charts. These are then added to Trust's IT systems to create an electronic record of the risk assessment.

- VTE risk assessment rates and the quality of these assessments continue to be reviewed by the VTE committee which meets on a bi-monthly basis. The Trust takes part in an MSB wide audit on VTE compliance which includes the risk assessment, prescription and administration of VTE prophylaxis and performance is presented at both the VTE Committee and Trust Clinical Governance Committee.

Clostridium difficile

The Trust continues to monitor data relating to healthcare associated infections (HAI) and reducing HAI remains a priority. Data is collected, analysed and published by Public Health England on the rate of clostridium difficile (C. diff) infections per 100,000 bed days reported amongst patients aged two or over.

The data below shows that the Trust breached the C diff ceiling for 2017/18 by 3 cases but some infections are as a consequence of factors beyond the control of the Trust.

Table 50: C. diff infections per 100,000 bed days

Period	Measure	Trust value	Rank	National Lowest	National Highest
1 April 2017 to 31 March 2018	**18.8**	13.7	130/151	0	91.0
1 April 2016 to 31 March 2017	**12.1**	13.2	78/153	0	82.7
1 April 2015 to 31 March 2016	**15.0**	14.9	91/154	0	66.0
1 April 2014 to 31 March 2015	**15.9**	15.0	96/154	0	62.2
1 April 2013 to 31 March 2014	**17.8**	14.7	116/154	0	37.1

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers that this rate is as described for the following reasons:

- Public Health England collates, analyses and reports data which is also monitored and reported locally to the Trust Board.
- For each post 72 hours of admission case of C. diff, a Route Cause Analysis is undertaken. This process involves the patient's consultant, Ward Manager, the Joint Commissioning Team, Infection Control Team, Matron and Consultant Microbiologist. Any direct lapses in care are identified and action plans are developed if required to address any issues identified.
- C diff is an agenda item on the Infection Control Committee and the C diff data and direct lapses in care are reported against each directorate

Southend University Hospital NHS Foundation Trust intends to take / has taken the following actions to improve this rate, and so the quality of its services, by:

- There is continuing adherence to strict antibiotic stewardship which includes antibiotic ward rounds and audits completed by the antibiotic pharmacist.
- All C diff cases follow an integrated care pathway.
- If required a weekly C. diff ward round is undertaken.
- All C diff infection patients and active C. diff carriers (GDH) are seen by a member of the Infection Prevention and Control Team (IPCT) on a weekly basis.
- Commodes audits are undertaken by the IPCT on a monthly basis

Patient safety incidents

Incident reporting and the reporting of near misses are actively encouraged to maximise learning potential and to prevent incidents from occurring. The Trust uses Datix, an electronic incident reporting system; although where electronic systems are not available staff also have the option of reporting via an anonymous telephone reporting line or by completing a paper incident form.

Table 51: Rate of patient safety incidents and the number and percentage of such patient safety incidents that result in severe harm or death

Period	Measure	Trust value	All Acute Trusts	Lowest Acute Trust	Highest Acute Trust
1 Oct 2017 to 31 Mar 2018	Number of incidents occurring	5,224	995,395	1,311	19,897
	Rate of Patient safety incidents per 1,000 bed days	55.5	n/a	24.2	124.0
	Percentage resulting in severe harm or death	0.40	n/a	0.00	1.55
1 Apr 2017 to 30 Sept 2017	Number of incidents occurring	4,326	981,839	1,133	15,228
	Rate of Patient safety incidents per 1,000 bed days	51.4	n/a	23.5	111.7
	Percentage resulting in severe harm or death	0.48	n/a	0.00	1.98
1 Oct 2016 to 31 Mar 2017	Number of incidents occurring	4,394	973,021	1,301	14,506
	Rate of Patient safety incidents per 1,000 bed days	48.9	n/a	23.1	69.0
	Percentage resulting in severe harm or death	0.52	n/a	0.03	2.13
1 Apr 2016 to 30 Sept 2016	Number of incidents occurring	4,320	952,274	1,485	13,485
	Rate of Patient safety incidents per 1,000 bed days	51.6	n/a	21.1	71.8
	Percentage resulting in severe harm or death	0.46	n/a	0.02	1.73

Data source: NHS Digital

Southend University Hospital NHS Foundation Trust considers that this number and / or rate are as described for the following reasons:

- The data is collected and analysed by the National Reporting and Learning System (NRLS).
- Data on the number of reported incidents and levels of harm are monitored by the Risk and Patient Safety Team, through the directorate monthly performance meetings and clinical governance meetings.
- The Trust traditionally has a high incident reporting rate and reflects the safety culture. This includes a high number of incidents with no harm and near misses. Monthly patient safety reports include data on the level of harm from NRLA and are generally around 95% with low or no harm.

Southend University Hospital NHS Foundation Trust intends to take / has taken the following actions to improve this number and / or rate, and so the quality of its services, by:

- In house RCA half day training sessions will continue to be offered to the clinical directorates a minimum of 4 times a year. Teaching sessions on patient safety and incident reporting for newly qualified nurses and overseas nurses continue to be provided as part of their induction programme. Bespoke training and Datix access is undertaken as required by the directorates.

- The Trust actively encourages patient safety reporting with continued promotion of the anonymous governance incident helpline to enable staff to raise incidents when they do not have easy access to a computer or wish to discuss a patient safety concern confidentially. In addition to this a member of the Risk and Patient Safety Team attends the daytime medical clinical handover and Safe@ Southend meeting to identify incidents from the information discussed and to share patient safety lessons, where appropriate.

- A trial has been undertaken of the revised 24hour review paperwork to align with the process across the MSB and a trial is due to commence of bespoke investigation paperwork for patient falls to improve the quality of information obtained from the investigators. A new quality checklist has also been introduced for all SI investigation to ensure consistency and quality checking. The format of the Datix system continues to be updated and responsive to the needs of the reporters and managers.

- The current Duty of Candour (DoC) process has been reviewed and the proposal to hand over responsibility for DoC to the directorates has been agreed. This will take place with the introduction of the new MSB Patient Safety processes.

- A review panel process continues for the appraisal of patient falls that cause moderate harm or above and for all category 2 and above hospital acquired pressure ulcers.

- Immediate learning and changes of practice following significant incidents are shared at Safe@ Southend trust wide patient safety meeting and learning from serious incidents at Mid Essex and Basildon Hospital have been shared via the trust incident newsletter. The hospital wide audit day provided an opportunity to share the learning from patient safety incidents, hospital acquired thrombosis and Never Events. In addition to this, a number of 'Patient Safety Kitchen Table Events' took place to enable staff to discuss patient safety concerns in a friendly confidential environment.

- A re-audit of the quality of incident investigations has been undertaken and demonstrates an improvement in the feedback provided to staff reporting incidents. A Staff survey to obtain feedback on incident reporting and patient safety in the trust continues and the focus of the survey to date has been ancillary staff including porters and domestic staff.

4.4 Part three: Quality of services

The Trust uses a number of different methods and information to monitor the quality of the services it provides both a Trust and directorate level. The quality priorities identified jointly with a number of stakeholder groups in 2016 were reviewed for 2018/19 and focus on areas of improving patient safety, patient experience and clinical effectiveness and take into account findings from our regulators, performance challenges and the organisation's safety priorities. Details of the trust performance against these priorities are included in section two of the quality report along with a description of the quality priorities for 2019/20.

4.4.1 Performance against 2018/19 key national priorities

Performance against the key national indicators and performance as set out in the NHSI Single Oversight Framework continue to be monitored to ensure that our services are accessible and meet expectations. Indicators for the Summary Hospital-level Mortality Indicator and Venous thromboembolism risk assessment are already reported in section 2 of this report.

Table 52: Summary of performance against NHSI Single Oversight Framework

Indicator	Threshold	2015-16	2016-17	2017-18	2018/19
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	93.72%	88.77%	84.49%	86.67%
A&E: Maximum waiting of 4 hours from arrival to admission / transfer / discharge.	95%	93.7%	83.46%	86.84%	87.05%
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer.	85%	77.0%	70.00%	72.80%	66.80%
All cancers: 62-day wait for first treatment from NHS cancer screening service referral.	90%	94.0%	94.60%	95.10%	87.50%
Clostridium difficile – variance from plan.	30	26	19	33	26
Maximum 6-week wait for diagnostic procedures.	99%	99.05%	97.28%	95.82%	98.40%

Data source: local data.

4.4.2 Additional quality reporting for 2018/19

Seven Day Services

In 2018, the seven day services project commenced to support the self-assessment process and implementation of actions to ensure compliance to the seven day services standards. The initial self-assessment was completed in February 2019, approved by the Trust Site Leadership Team and submitted to NHS Improvement. Assessment against delivering the four priority clinical standards can be seen below in Table 53.

Table 53: Seven day service standard

Clinical Standard	Weekday compliance	Weekend compliance	Overall compliance
Clinical standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Not met	Not met	Not met
Clinical standard 5: Hospital inpatients must have scheduled seven day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hours for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients	Standard met	Standard met	Standard met
Clinical standard 6: Hospital inpatients must have timely 24 hour access, seven days a week to key consultant-directed interventions that meet the relevant speciality guidelines either on-site or through formally agreed networked arrangements with clear written protocols.	Not met for intervenetional radiology and endoscopy	Not met for intervenetional radiology and endoscopy	Not met
Clinical standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care have been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Met twice daily for acutely ill patients but not met once daily for all other patients	Met twice daily for acutely ill patients but not met once daily for all other patients	Not met

Actions are being developed by the 7 day services project group to address the gaps in compliance. A project is currently underway to improve the recording of information against clinical standard 2 and a full assessment of consultant job plans is required to ensure this standard can be achieved. A pilot is due to commence to provide weekend interventional radiology across the MSB and a review of interventional endoscopy will be required to ensure this standard can be met. In order to meet clinical standard 8, a review of job plans and consultant of the week will be required in addition to improving the recording of whether the consultant has delegated authority for review on the basis that this would not affect the patient's care pathway.

Freedom to Speak up

The Trust has a number of different ways in which staff are able to raise concerns. Staff are encouraged to speak to their line manager or senior managers in the first instance. In November 2017 the Trust launched an independent and confidential Guardian Service for staff to discuss matters relating to patient care and safety, bullying and harassment and whistleblowing. The Guardian Service is available 24/7 and offers strictly confidential, non-judgemental, supportive liaison service and uses a red, amber, green approach to ensure issues are dealt with in an appropriate timeframe. Staff are assured that their meeting is strictly confidential, their anonymity will be maintained and issues will not be actioned without their permission.

In addition to the Guardian service, the Trust also has 'Speak Up' Champions from different directorates and who carry out various roles within the Trust including clinical and non-clinical. Speak Up Champions have received training from the Guardian Service to ensure a consistent approach and have support packs containing information to ensure they have the support required to carry out their role. The Speak Up Champions and Guardian Service meet bi-monthly to discuss themes and develop actions and monitor any issues.

Staff are also able to speak up using a variety of other methods including the Trust Human Resources Team, Staff Forum, Staffside Team and completing the staff survey.

Annual Report on Rota Gaps for NHS Doctors and Dentists in Training

Southend University Hospital recognises the importance of having a suitably resourced medical workforce and has developed a strategy to ensure that rota gaps are filled and minimised where possible. The table below shows the vacancies for doctors in training over the last 3 years.

Table 54: Rota Gaps

Trainee Grade	Posts in specialty Aug 2016	Monthly vacancy average Aug 2016 to Jul 2017	Posts in specialty Aug 2017	Monthly vacancy average Aug 2017 to Jul 2018	Posts in specialty Aug 2018	Monthly vacancy average Aug 2018 to Feb 2019
FY1	36	0.17	36	1	38	1
FY2	39	4.17	39	6.53	38	6.04
ST1-2	46	3.93	45	4.5	43	3.86
GPST	29	3.32	29	5.12	29	3.17
ST3+	63	12.99	66	12.35	68	15.04
Total	213	4.92	215	5.91	216	5.82

At the start of 2018 it was realised that the current approach was not producing effective results and the Trust continued to have a high number of vacancies and turnover. A resourcing officer was seconded to the Medical Directorate who had the highest number of vacancies to solely work on medical recruitment and support with the recruitment process. A monitoring system was put in place to track recruitment and issues were escalated promptly and resolved. A formalised structured induction plan was devised which included regular meetings with new recruitments to review their progress and address any issues. The next step is to develop a formalised structured training programme for Trust Grade doctors to increase recruitment and retention.

In 2018, the Trust has been recognised nationally as a high performing Trust for training in two specialties. In September 2018 the Royal College of Obstetricians and Gynaecologists recognised the Trust as a top UK unit for overall performance, gynaecological training and professional development and highly commended the Trust for obstetric training. The Trauma and Orthopaedic team were also voted as training hospital of the year 2018 by the Royal London Hospital Trauma and Orthopaedic Society.

4.4.3 Other areas of quality improvement during 2018/19

Radiotherapy achieves CHKS accreditation

The department of Radiotherapy and Radiotherapy Physics which uses radiation to help kill cancer cells has been accredited by CHKS for its processes and standards which meet international best practice standards. This means that the services, which sees cancer patients from right across Essex, are safe, reliable and of good quality. The also meet the high standards required by the Care Quality Commission giving the Trust a huge seal of approval when it comes to cancer care.

Teletracking

The Teletracking system was introduced across all 3 sites within the MSB in the Autumn 2018. The system provides real time information on patient flow, tracking patients through the hospital, providing an overview of the bed status on all 3 sites and providing information on where patients are on their journey home from hospital.

Gold Standards Framework Accreditation

Rochford, Westcliff and Windsor wards and the Palliative Care Team received the Gold Standards Framework (GSF) accreditation in September 2018 and were recognised with a national award for the quality of care they are providing for their patients as they approach the end of their lives. The GSF recognises that our ward teams work in a coordinated way to identify patients in their last year of life and, through advanced care planning, help patients make decisions about their care ensuring their wishes are documents and acted on.

Audiology achieves UKAS accreditation

In September 2018, the Audiology department were awarded a renewal of accreditation for audiology services against the IQIPS standard v1.0, 2012 from the United Kingdom Accreditation Service. The accreditation demonstrates that the service is competent to perform processes, activities and tasks in a reliable, credible and accurate manner.

Improved diagnostic testing for Urology Service

A new device called a flexible cystoscopy stack is now being use for patients undergoing diagnostic tests for suspected bladder cancer. The device, for use on men and women, incorporates a camera that can be placed through a patient's urethra to view the bladder and surrounding areas, including the prostate. It uses specialist technology, known as narrow-hand imagery, which highlights cancerous cells. The stack enables images to be viewed on screen by members of the urology team, assisting with diagnosis, taking biopsies or removing stents. It is much more comfortable for the patient and is more dignified.

Maternity and Gynaecology training recognised

The obstetrics and Gynaecology team has been recognised as the top training unit in the UK by the Royal College of Obstetricians and Gynaecologists for the experience it provides to trainees. The team was ranked among the top performing NHS Trusts in the country out of a total of 171 Trusts.

Launch of the diabetic foot pathway

A pathway for management of patients presenting with an acute diabetic foot problem has been developed for use in the Emergency Department (ED). The introduction of the pathway into Southend ED will ensure patients receive safe, clinically effective and person centred care in relation to their foot problem. It is clear and concise and provides the clinicians with step-by-step guide on how to manage the patient and how to provide appropriate on-ward care. This will ensure these patients are correctly assessed in A&E and are signposted to the Wound Management Team for urgent assessment and on-going care if clinically indicated.

Red bag scheme

The innovative red bag scheme was introduced to help provide a better care experience for care home residents by improving communication between care homes and hospitals. When a resident becomes unwell and is assessed as needing hospital care, staff from the care home pack a dedicated red bag that includes the resident's standardised paperwork and their medication as well as clothes for their discharge and other personal items.

Pharmacy innovations

In May 2018, the Pharmacy department introduced a new service which sends out patients' medicines discharge information electronically to their nominated community pharmacy, allowing the patient's pharmacist to know they have been in hospital, that their medicines have been changed and that the patient knows what their new medicines are for and address any concerns they may have.

4.5 Annex 1: Comments on Southend University Hospital Quality Account

The draft quality account was shared with Mid and South Essex CCGs, Healthwatch Southend, Healthwatch Essex, Southend Borough Council, Essex Health Overview, Policy and Scrutiny Committee and the Patient and Carer Experience Group.

No comments were received from Healthwatch Southend and Healthwatch Essex.

Clarifications were received from the Patient and Carer Experience Group and incorporated into the report.

The comments received on the content of the Quality Account from Mid and South Essex CCGs, Southend Borough Council and Essex Health Overview, Policy and Scrutiny Committee are below.

Response to Southend University Hospital NHS Foundation Trust Quality Report 2018-2019 from Southend Borough Council

The draft Quality Report / Account has been shared with the Chairman, Councillors and co-opted members of the People Scrutiny Committee at Southend-on-Sea Borough Council, which is the health scrutiny committee. Set out below is the response:-

1. The Committee is pleased to see what has been achieved in improving quality standards, however there are still improvements that can be made. Pressure on services with increased demand, high level of emergency attendances, high patient acuity and vacancies is impacting on ability to deliver these improvements, however learning through audit, staff survey, patient family and friends test and complaints, sharing that learning, have enabled the Hospital to continue to move forward.

2. The report highlights a number of concerns:-

- Acute adults Ward sepsis assessment to treatment is lower than ED compliance
- Breaches peak in November / December - why is this?
- The percentage of pressure ulcers with lapses in care against admissions has increased during the year, this may be due to reporting, but is also lack of basic nursing care
- Poor communication, especially around treatment plans and discharge, waiting for beds and waiting for treatment/discharge from hospital
- HCA recruitment due to the number of staff leaving soon after commencement of employment
- Delay commencing a pump after it has been prescribed. Also noted in the report are that pumps are routinely not locked, could be interfered with, or leant on
- Cdiff worse than national average
- Mortality rates slow to improve

3. The report seems to suggest that 'all is well' which isn't the view expressed to members by some residents.

4. There seems to be no mention about the stroke unit or the successful loan of the mobile stroke unit which is somewhat surprising.

5. Referring to the Table 51 of the report – the Committee is pleased to see Safe Care being deployed, which should improve CHPPD and patient outcomes, especially as "Reported Falls" seem to be getting worse. Although high incident reporting rate can reflect the safety culture, this appears to be significantly rising during 1 quarter of the year. This should help not only incidents of falls, but also pressure ulcer care and sepsis assessments.

6. Can the Committee have an update as to why suitable funding was not achieved for the ward accreditation scheme, as it is part of a package of improvement measures shown to work across NHS?

7. Also of concern is the Table on page 49 of the report and to Clinical standard 2 and to clinical standard 6 not being met.

8. Referring to page 17 of the report and specifically to the areas of concern identified - gynaecology and endoscopy – it is suggested that synchronising your e-job planning into e-Rostering system for Gastro Consultants, or just having oversight/visibility of manually built activities in e-rostering in Activity Manager, will help Clinic schedulers in Endoscopy to better manage the patient schedule, as will clinic cancellation notifications.

9. The Committee notes that there was a reduction in the number of patients recruited during the year due to the closure of particular studies in 2017/18 that were high recruiting and easy to recruit to studies. The Committee hopes this will not affect retention of R&D staff and funding.

10. The Committee notes that Healthwatch Southend did not provide comments on the previous year's report.

Fiona Abbott - Principal Democratic Services Officer, Health Scrutiny Lead Officer & Statutory Scrutiny Officer

Southend-on-Sea Borough Council

Response to Southend University Hospital NHS Foundation Trust Quality Report 2018-2019 from Essex Health Overview, Policy and Scrutiny Committee

Thank you for the opportunity to comment on your Quality Accounts.

Whilst recognising that we may have been commenting on an early draft we would recommend the importance of having a contents page at the beginning to help navigate around the contents.

We are encouraged to see that the response rates regarding inpatient and daily care are above the national average. Further disclosure on the percentage of negative comments received would have been useful to increase understanding of this area.

We are also pleased to see the score regarding the question asked of patients being involved in decisions about their care, has improved and would encourage continued focus on this important measure.

County Councillor Jill Reeves
Chairman, Essex Health Overview, Policy and Scrutiny Committee

Response to Southend University Hospital NHS Foundation Trust Quality Report 2018-2019 from Mid and South Essex CCGs

Mid and South Essex Joint Committee (JC) has devolved authority from mid and south Essex CCGs to commission "in hospital" services on their behalf. As the lead commissioner of services provided by Southend University Hospitals NHS Foundation Trust (SUHFT), the JC welcomes the opportunity to comment on this quality report.

The JC is commenting on a draft version of this quality account, however, to the best of the JC's knowledge, the information contained within this report is generally accurate and is representative of the quality of services delivered. Any queries will have been fed back to SUHFT prior to publication for consideration of inclusion, along with missing data in the final report.

Additional requirements for insertion within 2018/19 Quality Reports are:

A statement regarding progress in implementing the priority clinical standards for seven day hospital services and

Freedom to Speak up - details of ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust

Both of these are included with the 2018/19 Quality Account and it is encouraging to see the Trust's statement and project plans for progressing the seven day hospital services within the report.

When reflecting on the priorities which the Trust set for 2018/19, it is worth noting that this has been another challenging year with increasing demand for services. The Trust has partially achieved the quality goals set for 2018/19, with the outstanding ones having been reviewed by the Trust to determine whether they should remain for the forthcoming year, taking into consideration emerging areas for improvements. A full explanation of any not included in future priorities is detailed within the report.

It is noted that the Trust is still currently rated as "requires improvement" following the November 2017 visit from the Care Quality Commission (CQC) with overall "Good" ratings across all core services and with a rating of "Good" for the "Well Led" domain. The JC recognises the leadership and continuous work on the areas for improvement highlighted in the report published in April 2018, though the "Maintaining High Standards" programme.

There was significant progress within the Trust during 2017/18 in relation to the Summary Hospital Mortality Index (SHMI), and the JC note that during 2018/19 the SHMI remains within expected limits. However, there is concern that it is on a slight downward trajectory, which is an area that the JC will continue to monitor during 2019/20. It was reassuring to see a full breakdown of the deaths scrutinised by the medical examiners within the report, including the learning from deaths.

There are many areas of notable practice within the report, for example the anonymous governance incident helpline embedded at SUHFT and the persistent levels of the VTE Risk Assessments reported within SUHFT are above the national average.

A comprehensive description of the Trust's participation in and learning from clinical audit and research is produced, including a summary of findings and learning from all clinical audits undertaken. It is noted that during 2018/19, a number of returns for both national clinical audits and national confidential enquires were below the expected number. The JC acknowledges that the Trust has reviewed internal processes and escalation processes have been enhanced to identify any resource issues which can be mitigated to ensure that response rates increase.

The JC recognises the work that the Trust implemented in 2018 with the weekly review panel for all hospital acquired pressure ulcers category 2 and above. The process has been observed by the JC and is deemed as extremely robust and effective. It is recognised that the process has resulted in an increase in the number of pressure ulcers with lapses in care being reported, which was anticipated would occur by the Trust. The Trust now has a new baseline upon which to base improvement targets for 2019/20.

When reviewing the quality priorities for 2019/20 it is extremely encouraging to see a significant amount of joint working priorities across the 3 hospitals, Mid Essex Hospital Trust, Basildon University Hospital Trust and SUHFT detailed in the report.

In conclusion Mid and South Essex JC considers SUHFT Quality Report for 2018/19 as providing an accurate and balanced picture of the reporting period. The JC via its Acute Commissioning Team will continue to seek assurance on performance and delivery of care by regular monitoring through agreed contract processes.

Rachel Hearn
Director of Nursing and Quality

Acute Commissioning Team and Mid Essex Clinical Commissioning Group

4.6 Annex 2: Statement of Directors' responsibilities for the quality accounts

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2018 to 28 May 2019
    - papers relating to quality reported to the Board over the period April 2018 to 28 May 2019
    - feedback from the patient and carer experience group dated 25 April 2019
    - feedback from Southend-on-Sea Borough Council dated 9 May 2019
    - feedback from Essex Health Overview, Policy and Scrutiny Committee dated 10 May 2019
    - feedback from Mid and South Essex CCGs dated 16 May 2019

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2018
- the (latest) national patient survey June 2018
- the (latest) national staff survey February 2019
- the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
- CQC inspection report dated April 2018

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Clare Panniker
Chief Executive
Date: 29 May 2019

Alan Tobias OBE
Chairman
Date: 29 May 2019

4.7 Glossary for Quality Account

Accessible Information Standard – standards that all NHS and social care providers must follow to ensure that people who have a disability or sensory loss get information in a way they can access and understand

Advance Care Planning – is a process that enables individuals to make plans about their future health care and provides direction to healthcare professional when a person is not in a position to either make and / or communicate their own healthcare choices

Baywatch – An initiative to reduce in-hospital falls by ensuring that a member of nursing staff is always present in the patient bay on a ward to increase vigilance and ensure there is maximum observation of patients at risk of falling

Cardiac arrest – a cardiac arrest is the sudden loss of blood flow resulting from the failure of the heart to effectively pump

Case record review – a proportionate but detailed review of patient records using a structured review template to establish whether there were any problems in the care provided to the patient who died in order to learn from what happened.

Chronic obstructive pulmonary disease (COPD) – is a group of lung conditions that cause breathing difficulties

Clinical audit – measures the quality of care and services against agreed standards and makes improvements where needed

Clinical coding – the process whereby clinical information / statements are analysed and assigned codes using a specified classification system. The data produced is an integral part of health information management

Clinical Research Network (CRN) – makes it possible for patients and health professional across England to participate in clinical research studies within the NHS

Clostridium difficile (C. diff) – a bacterium that can infect the bowel and cause diarrhoea

Clinical Commissioning Group (CCG) – the organisation responsible for buying health services such as those provided by the hospital

Commissioning for quality and innovation (CQUIN) – a national framework for quality improvement schemes that results in a proportion of a providers income being conditional on the achievement of the quality improvement goals

Do not resuscitate (DNACPR) – also known as 'do not attempt cardiopulmonary resuscitation' is medical order written by a doctor. It instructs healthcare providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating.

Duty of Candour (DoC) – DoC places a legal obligation on all providers of health and adult social care to be open with people when things go wrong

Exit blocking – When patients cannot be moved from a hospital emergency department into a hospital bed

Fit to sit campaign – This is a national campaigned which encourages frontline staff to put an end to patients lying down on trolleys and stretchers if they are well enough to sit or stand

Fraser Guidelines – refer to guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice.

Friends and Family Test - The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS.

Gillick Competence – is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge

Hospital out of hours team (HOOH) – a team of senior nurses who support junior medical staff and provide senior clinical nursing support to the ward staff out of normal working hours (nights and weekends)

National Clinical Audit – clinical audits that look at care nationwide

National Confidential Enquires in Patient Outcomes and Death (NCEPOD) – NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

National Early Warning (NEWS) Score – used to quickly determine the degree of illness of a patient. Peri-arrest – is the period either before or after a cardiac arrest where the patient is in an unstable condition

Non-invasive ventilation (NIV) – is a method of delivering oxygen by positive pressure mask that allows the clinician to postpone or prevent the use of a tube down the throat

Patient Group Direction – A PGD provides a legal framework that allows some registered health professionals to administer specified medications to a pre-defined group of patients, without them having to see a prescriber.

Payment by Results (PbR) – is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated

Pressure ulcer – A pressure ulcer (also known as pressure sores or bed sores) are localised damage to the skin and / or underlying tissue that usually occur over a bony prominence as a result of pressure or pressure in combination with shear and / or friction.

Safer Nursing Care Tool (SNCT) – has been developed to help NHS hospital staff ensure that nursing establishments reflect patients' needs

Safety Cross – a safety cross is a visual data collection tool that is used to identify areas for improvement

Scrutiny – a proportionate and independent review of medical records with an aim of confirming cause of death and 'a close and searching look' for any concerns with poor care

Sepsis – also referred to as blood poisoning or septicaemia is a potentially life-threatening complication of an infection or injury

SSKIN – The SSKIN bundle is made up of five simple steps to prevent and treat pressure ulcers; Surface, make sure patients are nursed on the right surface; skin inspection; keep patients moving; incontinence and moisture, make sure patients are kept clean and dry; nutrition and hydration

SSKIN Champions – these are nurses identified in clinical areas to act as champions for pressure ulcer prevention

Structured judgement review (SJR) – The SJR is a tool used to review the care and treatment received by patients. It blends traditional, clinical judgement based review methods with a standard format. It requires reviewers to make safety and quality judgements over phases of care, make explicit written comments about care for each phase and to score care for each phase.

Summary hospital-level mortality indicator (SHMI) – the SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as a national statistic by NHS digital with each publication reporting on a 12 month period.

Treatment Escalation Plan (TEP) – A TEP is one mechanism of planning care of a patient at risk of deteriorating.

Venous Thromboembolism (VTE) – is a condition where a blood clot forms in a vein

WHO safety checklist – released by the World Health Organisation, the WHO surgical safety checklist is a tool used by relevant clinical teams in any operating environment to improve the safety

5. Auditors' Report

Independent auditor's report to the Council of Governors of Southend University Hospital NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of Southend University Hospital NHS Foundation Trust (the Trust) for the year ended 31 March 2019 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) as adopted by the European Union and as interpreted and adapted by the 2018-19 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2018-19, and the NHS Foundation Trust Annual Reporting Manual 2018-19 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of 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

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key Audit Matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Matter	How we addressed the matter in the audit
Fair value of property, plant and equipment (PPE) PPE is a significant balance on the Statement of Financial Position and there is a high degree of estimation involved in the value of these assets. There is a risk over the valuation of land and buildings where valuations are based on assumptions or where updated valuations have not been provided for a class of assets at year-end. *See Accounting Policy Note 1.7.2 and Notes 15 and 17 of the financial statements*	We reviewed the instructions provided to the valuer and considered the valuer's skills and expertise in order to determine the extent to which we could rely on Management's expert. We assessed Management's review of the Modern Equivalent Asset alternative site basis to determine whether this remained a valid judgement within the financial statements for 2018/19. We reviewed the desktop valuation referred to in Note 17 to the financial statements obtained by the Trust to assess whether the valuations are based on reasonable assumptions and the estimates provided by the valuer are reasonable. We also reviewed input data used by the valuer to ascertain their completeness and accuracy. We reviewed the valuation obtained by the Trust to ensure that the basis of valuation for assets valued in year is appropriate based on their usage, and valuation movements are in line with relevant indices of price movements. We also confirmed that all relevant classes of assets had been included.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements. We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonable users that are taken on the basis of the financial statements. Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the financial statements as a whole was set at £5 million (2018 - £4.794 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.75%) (2018 - 1.75%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £100,000 (2018 - £96,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

The Trust operates as a single entity with no significant subsidiary bodies or other controlled undertakings. Accordingly our audit was conducted as a full scope audit of the Trust.

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.

Qualified opinion on the Remuneration Report and Staff Report

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

Except for the matter referred to in the Basis for qualified opinion on information in the Remuneration Report and Staff Report paragraph of our report, 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 2018-19.

Basis for qualified opinion on information in the Remuneration Report and Staff Report

The Remuneration Report does not include the required pension benefit disclosures for a senior manager who has been omitted from the pension scheme due to an external administrative error. Pension contributions have not been made in respect of the senior manager for approximately 3 years and, consequently, the pension information has not been provided in the Remuneration Report.

This matter results in the 'Pension Related Benefits' and 'Total' columns of the Directors' remuneration 2018/19 table being incomplete for the senior manager in question and, similarly, the information included in all the columns of the Pensions table for 2018/19 being incomplete for the senior manager in question.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion on use of resources

The Trust's outturn for the year is a deficit of £7.5m after receiving Provider Sustainability Funding (PSF) of £16.3m for the year. The Trust has set a break even budget for 2019/20 but this will not reduce the £27.9m of revenue reserves deficit accumulated to 31 March 2019.

The Trust has significant loans from the Department of Health and Social Care, with £63.1m as at 31 March 2019. Of these loans, £30.4m are due for repayment in 2019/20, but are currently being renegotiated with the Department because there is forecast to be insufficient cash to repay what is due within the year.

The continuing cumulative deficits and levels of debt that cannot be serviced are evidence of weaknesses in proper arrangements regarding sustainable resource deployment.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit; or
- the Quality Report has been prepared in accordance with the detailed guidance issued by NHS Improvement.

We also report to you if we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibility, the Accounting Officer is 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 the Accounting Officer determines 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 Accounting Officer is 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 Council of Governors either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

The Accounting Officer is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

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.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

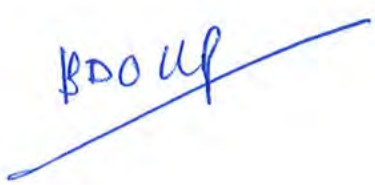
We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Southend University Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Council of Governors of Southend University Hospital NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of Southend University Hospital NHS Foundation Trust those matters we are required to state to it 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 NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.



David Eagles

For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK
29 May 2019

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

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Southend University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Southend University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2019 ("the Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as "the indicators".

Directors' responsibilities

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibilities

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Requirements for External Assurance for Quality Reports 2018/19 issued by NHS Improvement in December 2018 ("the Guidance"); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to 28 May 2019;
- papers relating to quality reported to the Board over the period April 2018 to 28 May 2019;
- feedback from commissioners;
- feedback from the Overview and Scrutiny Committee;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;

- the latest national patient survey, dated 13/06/2018;
- the latest national staff survey, dated 26/02/2019;
- Care Quality Commission inspection, dated 24/04/2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 25/04/2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Southend university Hospital NHS Foundation Trust as a body, in reporting Southend university Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Southend University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Southend University Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for External Assurance for Quality Reports 2018/19 issued by NHS Improvement in December 2018; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

BDO LLP

Chartered Accountants
Ipswich, UK

29 May 2019

6. Annual Accounts

Foreword to the accounts

Southend University Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Southend University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Clare Panniker
Chief Executive
Date: 29 May 2019

Statement of Comprehensive Income for the year ended 31st March 2019

	Note	2018/19 (£000)	2017/18 (£000)
Operating income from patient care activities	3	294,892	284,810
Other operating income	4	38,139	34,879
Operating expenses	6, 8	(335,974)	(326,075)
Operating surplus / (deficit) from continuing operations		**(2,943)**	**(6,386)**
Finance income	11	135	43
Finance expenses	12	(1,759)	(1,158)
PDC dividends payable		(2,899)	(3,486)
Net finance costs		**(4,523)**	**(4,601)**
Other gains / (losses)	13	-	(5)
Surplus / (deficit) for the year		**(7,466)**	**(10,992)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(3)
Revaluations	17	1,077	6,469
Total comprehensive income / (expense) for the period		**(6,389)**	**(4,526)**

Statement of financial position for the year ended 31st March 2019

	Note	31 March 2019 (£000)	31 March 2018 (£000)
Non-current assets			
Intangible assets	14	3,067	3,247
Property, plant and equipment	15	176,802	169,601
Receivables	20	747	628
Total non-current assets		**180,616**	**173,476**
Current assets			
Inventories	19	6,701	6,138
Receivables	20	30,491	24,514
Other assets	21	61	-
Non-current assets held for sale / assets in disposal groups	22	-	90
Cash and cash equivalents	23	15,589	18,932
Total current assets		**52,842**	**49,674**
Current liabilities			
Trade and other payables	24	(41,912)	(40,298)
Borrowings	26	(31,964)	(8,481)
Provisions	28	(276)	(244)
Other liabilities	25	(758)	(414)
Total current liabilities		**(74,910)**	**(49,437)**
Total assets less current liabilities		**158,547**	**173,712**
Non-current liabilities			
Borrowings	26	(38,943)	(48,690)
Provisions	28	(1,340)	(1,127)
Other liabilities	25	(936)	(1,054)
Total non-current liabilities		**(41,219)**	**(50,871)**
Total assets employed		**117,328**	**122,841**
Financed by			
Public dividend capital		107,098	106,221
Revaluation reserve		38,077	37,000
Income and expenditure reserve		(27,847)	(20,380)
Total taxpayers' equity		**117,328**	**122,841**

The notes on pages 168 to 212 form part of these accounts.

Clare Panniker
Chief Executive
Date: 29 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital (£000)	Revaluation reserve (£000)	Income and expenditure reserve (£000)	Total (£000)
Taxpayers' equity at 1 April 2018 - brought forward	**106,221**	**37,000**	**(20,380)**	**122,841**
Surplus/(deficit) for the year	-	-	(7,466)	**(7,466)**
Impairments	-	-	-	-
Revaluations	-	1,077	-	**1,077**
Public dividend capital received	877	-	-	**877**
Taxpayers' equity at 31 March 2019	**107,098**	**38,077**	**(27,847)**	**117,328**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital (£000)	Revaluation reserve (£000)	Income and expenditure reserve (£000)	Total (£000)
Taxpayers' equity at 1 April 2017 - brought forward	**103,039**	**34,753**	**(13,607)**	**124,185**
Prior period adjustment	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	**103,039**	**34,753**	**(13,607)**	**124,185**
Surplus/(deficit) for the year	-	-	(10,992)	**(10,992)**
Impairments	-	(3)	-	**(3)**
Revaluations	-	6,469	-	**6,469**
Public dividend capital received	-	(4,219)	4,219	**-**
	3,182	-	-	**3,182**
Taxpayers' equity at 31 March 2018	**106,221**	**37,000**	**(20,380)**	**122,841**

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 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.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows for the year ended 31st March 2019

	Note	2018/19 (£000)	2017/18 (£000)
Cash flows from operating activities			
Operating surplus deficit		(2,924)	(6,386)
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,522	10,678
Net impairments	7	2,128	3,238
Income recognised in respect of capital donations	4	(124)	(604)
Increase in receivables and other assets		(5,985)	(5,354)
(Increase) / decrease in inventories		(563)	174
Increase in payables and other liabilties		2,381	6,885
Decrease in provisions		(129)	(658)
Other movements in operating cash flows		-	34
Net cash generated from operating activities		**5,307**	**8,007**
Cash flows from investing activities			
Interest received		135	43
Purchase of intangible assets		(915)	(1,051)
Purchase of property, plant, equipment		(18,104)	(11,827)
Sales of property, plant, equipment		153	7,894
Receipt of cash donations to purchase capital assets		124	-
Net cash generated from / (used in) investing activities		**(18,607)**	**(4,941)**
Cash flows from financing activities			
Public dividend capital received		877	3,182
Net movement on loans from the Department of Health and Social Care		13,879	15,485
Net movement on other loans		(212)	1,092
Capital element of finance lease rental payments		-	(1,136)
Interest on loans		(780)	(523)
Interest paid on finance lease liabilities		(684)	(264)
PDC dividend paid		(3,123)	(3,488)
Net cash generated from financing activities		**9,957**	**14,348**
Increase / (decrease) in cash and cash equivalents		**(3,343)**	**17,414**
Cash and cash equivalents at 1 April - brought forward		**18,932**	**1,519**
Cash and cash equivalents at 31 March	23.1	**15,589**	**18,932**

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 2018/19 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 to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted 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, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

The Board have considered the Trust's current financial position, future financial plans and associated risks. and after making appropriate enquiries, the directors have a reasonable expectation that the Trust has adequate arrangements to continue in operational existence for the foreseeable future.

Although the Trust recorded a deficit in the year, it has slightly outperformed its control total and delivered a lower deficit in 2018/19 than the previous year. It is planning for a breakeven position for 2019/20. The Trust's performance and future planning is regularly discussed in detail with NHS Improvement (formerly Monitor).

Access to a revenue support loan to support the Trust's deficit has been utilised during 2018/19 and it is fully anticipated the Department of Health will continue to provide access to sufficient operating cash for the foreseeable future.

The Trust is also fully involved in the regional Sustainability and Transformation Plan designed to bring the local health system back into financial balance. It is also the designated acquiring Trust for the proposed merger with Mid Essex Hospital NHS Trust, and Basildon and Thurrock University NHS Foundation Trust which is proposed for 2020/21. This further safeguards the Trust's future.

For these reasons, the Board continue to adopt the going concern basis in preparing the accounts.

Note 1.3 Interests in other entities

NHS Charitable Fund

The Trust is the corporate trustee to Southend Hospital NHS Foundation Trust Charity. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary.

The Charitable Funds transactions and value, however, are deemed as immaterial to the Trust and are not consolidated within these financial statements.

Joint venture

In 2014/15 Southend University Hospital NHS Foundation Trust entered into a joint venture arrangement with Basildon & Thurrock University Hospitals NHS FT, each with a 25.5% interest, and Integrated Pathology Partnerships, with a 49% interest, to provide pathology services to primary and secondary acute and non-acute and private sector healthcare providers in Southend and Basildon.

This resulted in the creation of two limited liability partnerships, Pathology First LLP and Facilities First LLP. Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method, where the value of the Trust's investment is recorded under investments.

In 2018/19 the two partnerships traded only with the Southend and Basildon Trust's and broke even. They are not expected to show a profit until they begin trading with third party customers. As at 31st March 2019, the value of their assets is not material and, therefore, they are not consolidated in the accounts.

Note 1.4 Revenue from contracts with customers

Note 1.4.1 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 of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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 entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset 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. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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.

Employer's pension cost 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

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.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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.

A full formal valuation is carried out every 5 years, and the Trust has commissioned a Desktop Valuation as at 31st March 2019 to ensure the values in the accounts are materially correct.

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.

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.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives (see note 1.7.6) 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.

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 income.

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 all of the following criteria are met:

- 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 ie:
  - management are committed to a plan to sell the asset
  - 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. 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 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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
Land	-	-
Buildings, excluding dwellings	50	100
Dwellings	50	50
Plant & machinery	5	5
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	5	5

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 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

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
Information technology	5	5
Development expenditure	5	5
Websites	5	5
Software licences	5	5
Licences & trademarks	5	5
Patents	5	5
Other (purchased)	5	5
Goodwill	5	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.10 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 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 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 ONS.

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, ie, when receipt or delivery of the goods or services is made.

Note 1.12.2 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 or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are subsequently measured at amortised cost.

Financial liabilities are subsequently measured at amortised cost

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

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.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value trough income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets 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 1.12.3 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 1.13 Leases

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

Note 1.13.1 The trust as 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 as a liability 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 1.13.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

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 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 29.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

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

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with 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

(iii) 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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

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

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.18 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, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 1.19 Critical judgements in applying accounting policies

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

- Valuation methodologies and external indices applied to the Valuation of Land and Buildings conducted by the District Valuer
- Provisions including for injury benefit claims and early retirements, impairments of receivables, and others
- Depreciation rates applied to property, plant and equipment
- Classification of leases as operating or finance

Note 1.20 Sources of estimation uncertainty

Estimations as to the recoverability of receivables and the valuation of inventories have been made in determining the carrying amounts of these assets. No significant variations are expected.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The HM Treasury FReM does not require the following Standard and Interpretation to be applied in 2018/19. The government implementation date for IFRS 16 is 2019/20.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM: early adoption in not therefore permitted.

Note 2 Operating Segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Similarly, the large majority of the Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Trust Board and which includes senior professional non-executive directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered by the Board of Directors contains summary figures for the whole Trust together with graphical line charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cashflow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)

	2018/19 (£000)	2017/18 (£000)
Acute services		
Elective income	47,099	47,065
Non elective income	85,612	81,210
First outpatient income	18,579	17,728
Follow up outpatient income	25,085	23,630
A & E income	13,757	13,120
High cost drugs income from commissioners (excluding pass-through costs)	32,134	30,501
Other NHS clinical income	68,183	69,906
All services		
Private patient income	270	213
Agenda for Change pay award central funding	2,735	-
Other clinical income	1,438	1,437
Total income from activities	**294,892**	**284,810**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 (£000)	2017/18 (£000)
NHS England	54,101	50,596
Clinical commissioning groups	234,610	231,886
Department of Health and Social Care	2,757	-
Local authorities	1,716	678
Non-NHS: private patients	270	213
Non-NHS: overseas patients (chargeable to patient)	116	232
Injury cost recovery scheme	1,058	936
Non NHS: other	264	269
Total income from activities	**294,892**	**284,810**
Of which:		
Related to continuing operations	294,892	284,810

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19 (£000)	2017/18 (£000)
Income recognised this year	116	232
Cash payments received in-year	116	114
Amounts added to provision for impairment of receivables	176	86
Amounts written off in-year	7	31

Note 4 Other operating income

	2018/19 (£000)	2017/18 (£000)
Other operating income from contracts with customers:		
Research and development (contract)	1,321	1,645
Education and training (excluding notional apprenticeship levy income)	8,392	8,092
Non-patient care services to other bodies	1,692	1,848
Provider sustainability / sustainability and transformation fund income (PSF / STF)	16,322	13,006
Other contract income	9,985	9,353
Other non-contract operating income		
Receipt of capital grants and donations	124	604
Charitable and other contributions to expenditure	240	236
Rental revenue from operating leases	59	95
Other non-contract income	4	-
Total other operating income	**38,139**	**34,879**
Of which:		
Related to continuing operations	38,139	34,879

Note 5 Additional revenue information

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19 (£000)
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	414
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 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 license 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:

	2018/19 (£000)	2017/18 (£000)
Income from services designated as commissioner requested services	293,184	283,160
Income from services not designated as commissioner requested services	1,708	1,650
Total	**294,892**	**284,810**

Note 6 Operating expenses

Note 6.1 Operating expenses

	2018/19 (£000)	2017/18 (£000)
Purchase of healthcare from NHS and DHSC bodies	1,228	1,077
Purchase of healthcare from non-NHS and non-DHSC bodies	17,540	15,859
Staff and executive directors costs	203,830	195,444
Remuneration of non-executive directors	153	154
Supplies and services - clinical (excluding drugs costs)	26,020	26,359
Supplies and services - general	3,782	3,900
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	40,743	38,320
Inventories written down	-	-
Consultancy costs	1,097	1,301
Establishment	3,626	3,412
Premises	7,116	7,218
Transport (including patient travel)	310	249
Depreciation on property, plant and equipment	9,427	9,772
Amortisation on intangible assets	1,095	906
Net impairments	2,128	3,238
Movement in credit loss allowance: contract receivables / contract assets	(205)	
Movement in credit loss allowance: all other receivables and investments	-	1,765
Increase/(decrease) in other provisions	118	-
Change in provisions discount rate(s)	(13)	8
Audit fees payable to the external auditor		
audit services- statutory audit	62	62
other auditor remuneration (external auditor only)	6	6
Internal audit costs	103	97
Clinical negligence	11,472	10,685
Legal fees	-	221
Education and training	1,058	916
Rentals under operating leases	1,062	909
Redundancy	-	160
Losses, ex gratia & special payments	189	270
Other	4,008	3,767
Total	**335,955**	**326,075**
Of which:		
Related to continuing operations	335,955	326,075

Note 6.2 Other auditor remuneration

	2018/19 (£000)	2017/18 (£000)
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	6	6
Total	**6**	**6**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 7 Impairment of assets

	2018/19 (£000)	2017/18 (£000)
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,128	3,238
Total net impairments charged to operating surplus / deficit	**2,128**	**3,238**
Impairments charged to the revaluation reserve	**-**	**3**
Total net impairments	**2,128**	**3,241**

A market review was undertaken in 2018/19 with a valuation date of 31 March 2019 by an independent valuer assessing of changes to the Trust's estate value. This resulted in impairments charged to the operating (deficit) of £2,888k and reversals of previous impairments credited to the operating (deficit) of £760k, a net deficit of £2,128k. In addition the reversal of depreciation in respect of upwards revaluations was recognised in the revaluation reserve, which had a value of £1,077k.

The Trust's land and buildings were fully revalued by an independent valuer during 2015/16.

Note 8 Employee benefits

	2018/19 (£000)	2017/18 (£000)
Salaries and wages	155,578	147,258
Social security costs	15,988	13,771
Apprenticeship levy	774	693
Employer's contributions to NHS pensions	17,539	16,350
Pension cost - other	12	-
Temporary staff (including agency)	14,740	18,476
Total gross staff costs	**204,631**	**196,548**
Of which		
Costs capitalised as part of assets	801	944
Total net staff costs	**203,830**	**195,604**

Note 8.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £0k (£368k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 Southend University Hospital NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

During 2011/12 the Trust granted an operting lease over its retail units within the hospital grounds with a 25 year term and the annual operating lease income of £59K.

Operating lease revenue	2018/19 (£000)	2017/18 (£000)
Minimum lease receipts	59	59
Other	-	36
Total	**59**	**95**

Future minimum lease receipts due:	31 March 2019 (£000)	31 March 2018 (£000)
- not later than one year;	59	59
- later than one year and not later than five years;	234	234
- later than five years.	703	761
Total	**996**	**1,054**

Note 10.2 Southend University Hospital NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

The Trust has entered into leases for buildings and to renew medical equipment throughtout the hospital.

Operating lease expense	2018/19 (£000)	2017/18 (£000)
Minimum lease payments	1,062	909
Total	**1,062**	**909**

Future minimum lease payments due:	31 March 2019 (£000)	31 March 2018 (£000)
- not later than one year;	587	591
- later than one year and not later than five years;	1,936	1,739
- later than five years.	601	1,002
Total	**3,124**	**3,332**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19 (£000)	2017/18 (£000)
Interest on bank accounts	135	43
Total finance income	**135**	**43**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 (£000)	2017/18 (£000)
Interest expense:		
Loans from the Department of Health	824	587
Finance leases	562	531
Total interest expense	**1,386**	**1,118**
Unwinding of discount on provisions	373	40
Total finance costs	**1,759**	**1,158**

Note 13 Other gains / (losses)

	2018/19 (£000)	2017/18 (£000)
Losses on disposal of assets	-	(5)
Total other losses	**-**	**(5)**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2018/19

	Software licences (£000)	Total (£000)
Valuation / gross cost at 1 April 2018 - brought forward	**9,164**	**9,164**
Additions	915	915
Valuation / gross cost at 31 March 2019	**10,079**	**10,079**
Amortisation at 1 April 2018 - brought forward	**5,918**	**5,918**
Provided during the year	**1,095**	**1,095**
Amortisation at 31 March 2019	**7,013**	**7,013**
Net book value at 31 March 2019	**3,067**	**3,067**
Net book value at 1 April 2018	**3,247**	**3,247**

Note 14.2 Intangible assets - 2017/18

	Software licences (£000)	Total (£000)
Valuation / gross cost at 1 April 2017 - as previously stated	**8,832**	**8,832**
Additions	1,057	1,057
Disposals / derecognition	(725)	(725)
Valuation / gross cost at 31 March 2018	**9,164**	**9,164**
Amortisation at 1 April 2017 - as previously stated	**5,737**	**5,737**
Provided during the year	906	**906**
Disposals / derecognition	(725)	**(725)**
Amortisation at 31 March 2018	**5,918**	**5,918**
Net book value at 31 March 2018	**3,247**	**3,247**
Net book value at 1 April 2017	**3,096**	**3,096**

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2018/19

	Land (£000)	Buildings excluding dwellings (£000)	Dwellings (£000)	Assets under construction (£000)	Plant & machinery (£000)	Transport equipment (£000)	Informa-tion technology (£000)	Furniture & fittings (£000)	Total (£000)
Valuation/gross cost at 1 April 2018 - brought forward	**20,655**	**113,507**	**6,960**	**2,017**	**49,337**	**159**	**30,903**	**4,674**	**228,212**
Additions	-	11,637	58	2,008	2,055	-	1,536	448	**17,742**
Impairments	-	(2,888)	-	-	-	-	-	-	**(2,888)**
Reversals of impairments	-	760	-	-	-	-	-	-	**760**
Revaluations	(770)	(3,058)	329	-	-	-	-	-	**(3,499)**
Disposals / derecognition	-	-	-	-	(776)	-	(13)	-	**(789)**
Valuation/gross cost at 31 March 2019	**19,885**	**119,958**	**7,347**	**4,025**	**50,616**	**159**	**32,426**	**5,122**	**239,538**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**0**	**-**	**-**	**30,262**	**159**	**25,342**	**2,848**	**58,611**
Provided during the year	-	4,320	256	-	3,338	-	1,437	76	**9,427**
Revaluations	-	(4,320)	(256)	-	-	-	-	-	**(4,576)**
Disposals / derecognition	-	-	-	-	(713)	-	(13)	-	**(726)**
Accumulated depreciation at 31 March 2019	**-**	**0**	**-**	**-**	**32,887**	**159**	**26,766**	**2,924**	**62,736**
Net book value at 31 March 2019	**19,885**	**119,958**	**7,347**	**4,025**	**17,729**	**-**	**5,660**	**2,198**	**176,802**
Net book value at 1 April 2018	**20,655**	**113,507**	**6,960**	**2,017**	**19,075**	**-**	**5,561**	**1,826**	**169,601**

Note 15.2 Property, plant and equipment - 2017/18

	Land (£000)	Buildings excluding dwellings (£000)	Dwellings (£000)	Assets under construction (£000)	Plant & machinery (£000)	Transport equipment (£000)	Information technology (£000)	Furniture & fittings (£000)	Total (£000)
Valuation / gross cost at 1 April 2017	**28,195**	**110,496**	**6,123**	**(0)**	**70,750**	**159**	**29,218**	**4,596**	**249,537**
Additions	-	9,089	14	2,017	2,397	-	1,685	78	**15,280**
Impairments	-	(5,310)	-	-	(248)	-	-	-	**(5,558)**
Reversals of impairments	-	2,317	-	-	-	-	-	-	**2,317**
Revaluations	335	(3,085)	823	-	(1,739)	-	-	-	**(3,666)**
Transfers to / from assets held for sale	-	-	-	-	(90)	-	-	-	**(90)**
Disposals / derecognition	(7,875)	-	-	-	(21,733)	-	-	-	**(29,608)**
Valuation/gross cost at 31 March 2018	**20,655**	**113,507**	**6,960**	**2,017**	**49,337**	**159**	**30,903**	**4,674**	**228,212**
Accumulated depreciation at 1 April 2017	**-**	**3,925**	**204**	**-**	**49,643**	**159**	**23,984**	**2,769**	**80,684**
Provided during the year	-	4,299	208	-	3,828	-	1,358	79	**9,772**
Revaluations	-	(8,224)	(412)	-	(1,499)	-	-	-	**(10,135)**
Disposals / derecognition	-	-	-	-	(21,710)	-	-	-	**(21,710)**
Accumulated depreciation at 31 March 2018	**-**	**0**	**-**	**-**	**30,262**	**159**	**25,342**	**2,848**	**58,611**
Net book value at 31 March 2018	**20,655**	**113,507**	**6,960**	**2,017**	**19,075**	**-**	**5,561**	**1,826**	**169,601**
Net book value at 1 April 2017	**28,195**	**106,571**	**5,919**	**(0)**	**21,107**	**-**	**5,234**	**1,827**	**168,853**

Note 15.3 Property, plant and equipment financing - 2018/19

	Land (£000)	Buildings excluding dwellings (£000)	Dwell-ings (£000)	Assets under construc-tion (£000)	Plant & machin-ery (£000)	Informa-tion technology (£000)	Furniture & fittings (£000)	Total (£000)
Net book value at 31 March 2019								
Owned - purchased	19,115	119,605	1,817	2,008	10,863	4,356	2,178	**159,942**
Finance leased	-	234	5,530	-	5,134	1,152	-	**12,050**
Owned - government granted	-	-	-	2,017	177	143	-	**2,337**
Owned - donated	-	889	-	-	1,555	9	20	**2,473**
NBV total at 31 March 2019	**19,115**	**120,728**	**7,347**	**4,025**	**17,729**	**5,660**	**2,198**	**176,802**

Note 15.4 Property, plant and equipment financing - 2017/18

	Land (£000)	Buildings excluding dwellings (£000)	Dwell-ings (£000)	Assets under construc-tion (£000)	Plant & machin-ery (£000)	Informa-tion technology (£000)	Furniture & fittings (£000)	Total (£000)
Net book value at 31 March 2018								
Owned - purchased	20,655	112,393	1,165	2,017	9,818	4,213	1,803	**152,064**
Finance leased	-	234	5,795	-	5,134	1,153	-	**12,316**
Owned - government granted	-	-	-	-	2,147	182	-	**2,329**
Owned - donated	-	880	-	-	1,976	13	23	**2,892**
NBV total at 31 March 2018	**20,655**	**113,507**	**6,960**	**2,017**	**19,075**	**5,561**	**1,826**	**169,601**

Note 16 Donations of property, plant and equipment

The Trust has received £124k (2017/18 £604k) of donated assets and cash from the Hospitals Charitable Fund for improvement to building and environment and small equipment purchases.

Note 17 Revaluations of property, plant and equipment

The Trust's land and buildings were last revalued by an independent valuer during 2015/16 with an effective valuation date of 31 March 2016. Any revalutaion surplus is transferred to the revaluation reserve. Any downward revaluation is charged against the revaluation reserve to the extent that it relates to the land or building concerned. Any additional deficit is charged to the Statement of Comprehensive Income. Any increase in valuation of any asset previously impaired in this way will first have a reversal of the previous impairement credited to the Statement of Comprehensive Income. Further detail can be found in note 1.5.

A market review was undertaken in 2018/19 with a valuation date of 31 March 2019 by an independent valuer assessing of changes to the Trust's estate value. This resulted in impairments charged to the operating (deficit) of £2,888k and reversals of previous impairments credited to the operating (deficit) of £760k, a net deficit of £2,128k. There was also an upwards revaluation of £1,077k, credited to the revaluation reserve.

Note 18 Disclosure of interests in other entities

Southend Hospital Charitable Fund	31 March 2019 (£000)	31 March 2018 (£000)
Income	1,047	1,007
Expenditure	(779)	(1,461)
	268	**(454)**
Fund value	1,645	1,377

The Trust is the corporate trustee to Southend Hospital NHS Foundation Trust Charity. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary.

The Charitable Funds are transactions and value, however, are deemed as immaterial to the Trust and are not consolidated within these financial statements.

The charitable fund's statutory accounts are prepared to 31 March 2018 in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

Note 19 Inventories

	31 March 2019 (£000)	31 March 2018 (£000)
Drugs	3,020	2,931
Consumables	3,629	3,165
Energy	52	42
Total inventories	**6,701**	**6,138**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £63,749k (2017/18: £57,032k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 20 Receivables

Note 20.1 Trade receivables and other receivables

	31 March 2019 (£000)	31 March 2018 (£000)
Current		
Contract receivables*	31,657	
Trade receivables*		6,352
Accrued income*		14,213
Allowance for impaired contract receivables / assets*	(2,388)	
Allowance for other impaired receivables	-	(2,579)
Prepayments	61	2,341
PDC dividend receivable	236	12
VAT receivable	54	556
Other receivables	871	3,619
Total current trade and other receivables	**30,491**	**24,514**
Non-current		
Allowance for impaired contract receivables / assets*	(174)	
Allowance for other impaired receivables	-	(188)
Other receivables	921	816
Total non-current trade and other receivables	**747**	**628**
Of which receivables from NHS and DHSC group bodies:		
Current	25,889	16,371

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets (£000)	All other receivables (£000)
Allowances as at 1 Apr 2018 - brought forward		-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,767	(2,767)
Allowances at start of period for new FTs	-	-
New allowances arising	458	-
Changes in existing allowances	(3)	-
Reversals of allowances	(660)	-
Allowances as at 31 Mar 2019	**2,562**	**(2,767)**

Note 21 Other assets

	31 March 2019 (£000)	31 March 2018 (£000)
Current		
Other assets	61	-
Total other current assets	**61**	**-**

Note 22 Non-current assets held for sale and assets in disposal groups

	2018/19 (£000)	2017/18 (£000)
NBV of non-current assets for sale and assets in disposal groups at 1 April	90	-
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	90	-
Assets classified as available for sale in the year	-	90
Assets sold in year	(90)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	90

Note 23 Cash

Note 23.1 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.

	2018/19 (£000)	2017/18 (£000)
At 1 April	**18,932**	**1,519**
Net change in year	(3,343)	17,413
At 31 March	**15,589**	**18,932**
Broken down into:		
Cash at commercial banks and in hand	457	82
Cash with the Government Banking Service	15,132	18,850
Total cash and cash equivalents as in Statement of Financial Position	**15,589**	**18,932**
Total cash and cash equivalents as in Statement of Cash Flow	**15,589**	**18,932**

Note 23.2 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019 (£000)	31 March 2018 (£000)
Bank balances	1	1
Total third party assets	**1**	**1**

Note 24 Trade and other payables

	31 March 2019 (£000)	31 March 2018 (£000)
Current		
Trade payables	12,905	7,853
Capital payables	5,548	5,962
Accruals	15,310	19,122
Social security costs	4,247	3,818
Accrued interest on loans*		146
Other payables	3,902	3,397
Total current trade and other payables	**41,912**	**40,298**
Of which payables to NHS and DHSC group bodies:		
Current	9,521	4,027

Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 26. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 25 Other liabilities

	31 March 2019 (£000)	31 March 2018 (£000)
Current		
Deferred income: contract liabilities	758	414
Total other current liabilities	**758**	**414**
Non-current		
Deferred income: contract liabilities	936	1,054
Total other non-current liabilities	**936**	**1,054**

Note 26 Borrowings

	31 March 2019 (£000)	31 March 2018 (£000)
Current		
Loans from the Department of Health and Social Care	30,406	7,000
Other loans	423	423
Obligations under finance leases	1,135	1,058
Total current borrowings	**31,964**	**8,481**
Non-current		
Loans from the Department of Health and Social Care	32,699	42,036
Other loans	1,058	1,269
Obligations under finance leases	5,186	5,385
Total non-current borrowings	**38,943**	**48,690**

Note 26.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC (£000)	Other loans (£000)	Finance leases (£000)	Total (£000)
Carrying value at 1 April 2018	**49,036**	**1,692**	**6,443**	**57,171**
Cash movements:				
Financing cash flows - payments and receipts of principal	13,879	(212)	-	13,667
Financing cash flows - payments of interest	(780)	-	(684)	(1,464)
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	146	-	-	146
Application of effective interest rate	824	-	562	1,386
Other changes	-	1	-	1
Carrying value at 31 March 2019	**63,105**	**1,481**	**6,321**	**70,907**

Note 27 Finance leases

Note 27.1 Southend University Hospital NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2019 (£000)	31 March 2018 (£000)
Gross lease liabilities	**8,245**	**9,034**
of which liabilities are due:		
- not later than one year;	1,566	1,540
- later than one year and not later than five years;	4,417	4,895
- later than five years.	2,262	2,599
Finance charges allocated to future periods	(1,924)	(2,591)
Net lease liabilities	**6,321**	**6,443**
of which payable:		
- not later than one year;	1,135	1,058
- later than one year and not later than five years;	3,569	3,614
- later than five years.	1,617	1,771

Note 28 Provisions

Note 28.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs (£000)	Legal claims (£000)	Total (£000)
At 1 April 2018	**1,131**	**240**	**1,371**
Change in the discount rate	(13)	-	**(13)**
Arising during the year	-	118	**118**
Utilised during the year	(126)	(108)	**(234)**
Unwinding of discount	373	-	**373**
At 31 March 2019	**1,366**	**250**	**1,616**
Expected timing of cash flows:			
- not later than one year;	156	120	**276**
- later than one year and not later than five years;	653	130	**783**
- later than five years.	557	0	**557**
Total	**1,366**	**250**	**1,616**

Note 28.2 Clinical negligence liabilities

At 31 March 2019, £58,733k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Southend University Hospital NHS Foundation Trust (31 March 2018: £53,372k).

Note 29 Contingent assets and liabilities

Value of contingent liabilities	31 March 2019 (£000)	31 March 2018 (£000)
NHS Litigation Authority legal claims		
Gross value of contingent liabilities	**(51)**	**(70)**
Net value of contingent liabilities	**(51)**	**(70)**

Note 30 Contractual capital commitments

	31 March 2019 (£000)	31 March 2018 (£000)
Property, plant and equipment	1,467	3,334
Total	**1,467**	**3,334**

Note 31 Financial instruments

Note 31.1 Financial risk management

IFRS 7, Financial Instruments, 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 the business entities. Also financial instruments play a much more limited role in creating or changing risk than would be of listed companies to which IFRS 7 mainly applies. 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.

Cash deposits with financial institutions are controlled by the Trust's Managing Operating Cash policy and this is monitored by the Finance and Resource Committee. The policy provides that deposits may only be made with "A" rated institutions, or Government Banking services, and in addition operates additional single deposit, banking group and concentration limits.

Liquidity risk

The Trust's net operating costs are incurred under annual service contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Interest - Rate Risk

The Trust's borrowings to support the deficit trading position are from the Department of Health at government borrowing rates, these are marginally above UK base rates. All existing borrowings from the DoH are fixed interest rates.

Where the Trust's Financial Assets and Libilities are subject to floating interest rates these are all based on the prevailing Base Rate. The Trust is not, therefore exposed to material interest-rate risk.

Note 31.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost (£000)	Held at fair value through I&E (£000)	Held at fair value through OCI (£000)	Total book value (£000)
Trade and other receivables excluding non financial assets	30,887	-	-	**30,887**
Cash and cash equivalents at bank and in hand	15,589	-	-	**15,589**
Total at 31 March 2019	**46,476**	-	-	**46,476**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables (£000)	Assets at fair value through the I&E (£000)	Held to maturity (£000)	Available-for-sale (£000)	Total book value (£000)
Trade and other receivables excluding non financial assets	20,611	-	-	-	**20,611**
Cash and cash equivalents at bank and in hand	18,932	-	-	-	**18,932**
Total at 31 March 2018	**39,543**	-	-	-	**39,543**

Note 31.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost (£000)	Held at fair value through the I&E (£000)	Total book value (£000)
Loans from the Department of Health and Social Care	63,105	-	**63,105**
Obligations under finance leases	6,321	-	**6,321**
Other borrowings	1,481	-	**1,481**
Trade and other payables excluding non financial liabilities	37,646	-	**37,646**
Total at 31 March 2019	**108,553**	-	**108,553**

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Other financial liabilities (£000)	Held at fair value through the I&E (£000)	Total book value (£000)
Loans from the Department of Health and Social Care	49,036	-	**49,036**
Obligations under finance leases	6,443	-	**6,443**
Other borrowings	1,692	-	**1,692**
Trade and other payables excluding non financial liabilities	34,188	-	**34,188**
Provisions under contract	1,371	-	**1,371**
Total at 31 March 2018	**92,730**	**-**	**92,730**

Note 31.4 Maturity of financial liabilities

	31 March 2019 (£000)	31 March 2018 (£000)
In one year or less	69,610	42,913
In more than one year but not more than two years	-	1,480
In more than two years but not more than five years	38,943	46,054
In more than five years	-	2,283
Total	**108,553**	**92,730**

Note 32 Losses and special payments

	2018/19		2017/18	
	Total number of cases (£000)	Total value of cases (£000)	Total number of cases (£000)	Total value of cases (£000)
Losses				
Cash losses	5	7	-	-
Bad debts and claims abandoned	9	7	55	42
Stores losses and damage to property	2	170	1	225
Total losses	**16**	**184**	**56**	**267**
Special payments				
Ex-gratia payments	19	5	18	3
Total special payments	**19**	**5**	**18**	**3**
Total losses and special payments	**35**	**189**	**74**	**270**

Note 33 New standards

Note 33.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £146k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £3,394k.

Note 33.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 34 Related parties

Southend University Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Southend University Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party and the Trust takes advantage of reduced disclosure under IAS 24 as all parties are under the same government control. During the year Southend University Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Southend Borough Council in respect of rates for the Hospital Sites. Transactions with HM Treasury in respect of Social Security costs and NHS Pension Agency in respect of employer's pension costs.

All transactions with these related parties have been carried out on normal trading terms and there are no securities or guarantees with any related party.

The related party transactions described above are summarised in the table below. Where individual trusts or Government Departments transactions are not material these have been grouped together.

The Trust has also received revenue and capital payments from a number of charitable funds, including Southend Hospital NHS Trust Charity for which Southend University Hospital NHS Foundation Trust is the Corporate Trustee. The audited accounts of Southend Hospital NHS Trust Charity are available from: Finance Department, Britannia House, Comet Way, Southend-on-Sea, Essex, SS2 6GE. The Charity has not been consolidated into the results of the Trust as per note 1.3. There are no cross guarantees between the NHS Charity and the Trust.

The Corporate Trustee is free to act independently of hospital management. Although recommendations of management are taken into account by the Corporate Trustee, it is not bound to accept them and may choose to use the charitable funds in a different way but always in accordance with the charity's objectives.

The Pathology/Facilities Joint Venture is also a related party and an asset transfer of £50k occurred at conception. It is not consider material, note 1.3 relates.

34 Cont. - Related parties

2018/19	Income from Related Party (£000)	Expenditure with Related Party (£000)	Amounts due from Related Party (£000)	Amounts owed to Related Party (£000)
NHS Foundation Trusts	**7,569**	**3,251**	**2,896**	**5,774**
Basildon And Thurrock University Hospitals NHS Foundation Trust	4,108	1,504	2,111	4,380
South Essex Partnership University NHS Foundation Trust	1,169	1,187	463	1,194
North East London NHS Foundation Trust	1,762	-	157	-
Oxford Health NHS Foundation Trust	247	104	25	7
Other	283	456	140	193
English NHS Trusts	**4,643**	**977**	**734**	**1,464**
Mid Essex Hospital Services NHS Trust	3,586	542	607	1,334
Barts Health NHS Trust	924	399	105	115
The Princess Alexandra Hospital NHS Trust	93	**2**	-	**-**
Barking, Havering and Redbridge University Hospitals NHS Trust	24	6	10	11
Other	16	28	12	4
Clinical Commissioning Groups	**233,624**	**15**	**4,100**	**965**
NHS Southend CCG	109,824	-	1,341	488
NHS Castle Point and Rochford CCG	103,893	7	1,087	444
NHS Basildon and Brentwood CCG	9,340	-	231	-
NHS Thurrock CCG	4,934	-	183	-
NHS Mid Essex CCG	2,653	-	150	-
NHS Havering CCG	587	-	469	-
NHS North East Essex CCG	313	-	91	-
NHS West Essex CCG	127	-	81	-
NHS Barking and Dagenham CCG	116	-	77	-
NHS Redbridge CCG	81	-	26	-
Other	1,756	8	364	33

2018/19	Income from Related Party (£000)	Expenditure with Related Party (£000)	Amounts due from Related Party (£000)	Amounts owed to Related Party (£000)
Other DH Bodies	**82,995**	**11,923**	**17,623**	**761**
NHS England	71,860	-	17,538	141
Health Education England	8,378	3	34	-
NHS Resolution		11,472	-	33
CQC	-	-	-	-
NHS Property Services	-	189	-	550
NHS Improvement	-	213	-	-
Other	2,757	46	51	37
Central Government WGA bodies	**-**	**33,528**	**69**	**6,723**
NHS Pension Scheme		16,761		4,247
HM Revenue & Customs		16,762	54	2,476
Welsh Health Bodies	-	5	15	-
Local Authorities	**1,716**	**0**	**319**	**0**
Southend-on-Sea Borough Council	1,716	-	319	-

34 Cont. - Related parties

2017/18	Income from Related Party (£000)	Expenditure with Related Party (£000)	Amounts due from Related Party (£000)	Amounts owed to Related Party (£000)
NHS Foundation Trusts	**5,512**	**1,660**	**1,421**	**1,534**
Basildon And Thurrock University Hospitals NHS Foundation Trust	3,545	354	933	709
South Essex Partnership University NHS Foundation Trust	1,200	951	411	545
North East London NHS Foundation Trust	349	-	-	29
Oxford Health NHS Foundation Trust	223	91	24	12
Other	195	264	53	239
English NHS Trusts	**2,901**	**723**	**642**	**351**
Mid Essex Hospital Services NHS Trust	1,685	412	542	154
Barts Health NHS Trust	1,125	259	65	59
The Princess Alexandra Hospital NHS Trust	66	-	9	-
Barking, Havering and Redbridge University Hospitals NHS Trust	15	6	19	4
Other	10	46	7	134
Clinical Commissioning Groups	**231,304**	**-**	**5,617**	**1,661**
NHS Southend CCG	110,066	-	3,512	23.00
NHS Castle Point and Rochford CCG	103,145	-	963	19
NHS Basildon and Brentwood CCG	8,604	-	11	1,294
NHS Thurrock CCG	4,428	-	7	325
NHS Mid Essex CCG	1,489	-	323	-
NHS Havering CCG	800	-	111	-
NHS North East Essex CCG	430	-	1	-
NHS West Essex CCG	217	-	3	-
NHS Barking and Dagenham CCG	145	-	54	-
NHS Redbridge CCG	122	-	35	-
Other	1,858	-	597	-

2017/18	Income from Related Party (£000)	Expenditure with Related Party (£000)	Amounts due from Related Party (£000)	Amounts owed to Related Party (£000)
Other DH Bodies	**73,601**	**11,021**	**8,679**	**305**
NHS England	65,280	-	8,645	-
Health Education England	8,163	3	34	-
NHS Resolution		10,685	-	-
CQC	-	246	-	-
NHS Property Services	-	-	-	223
Other	158	87	-	82
Central Government WGA bodies	**1,356**	**30,820**	**602**	**6,142**
NHS Pension Scheme	-	16,350	-	2,324
HM Revenue & Customs	-	14,464	556	3,818
Welsh Health Bodies	-	5	-	-
Other	-	1	46	-
Local Authorities	**678**	**-**	**370**	**-**
Essex County Council	678	-	285	-
Southend-on-Sea Borough Council	-	-	85	-

Appendix 1: List of Services

The list below highlights the essential services which form part of the Trust's contracts.

- General surgery
- Urology
- Trauma and orthopaedics
- Ear, nose and throat (ENT)
- Oral surgery
- Orthodontics
- Accident and emergency (A&E)
- ITU
- HDU
- Foetal Medicine
- General medicine
- Gastroenterology
- Endocrinology
- Clinical haematology
- Pathology
- Palliative medicine
- Cardiology
- Dermatology
- Neurology
- Clinical neuro-physiology
- Rheumatology
- Geriatric medicine
- Obstetrics
- Gynaecology
- Clinical oncology
- Radiology
- Histopathology
- Pain management
- Clinical microbiology
- Neonatology
- Diabetic medicine
- Elderly medicine
- Oncology
- Ophthalmology
- Respiratory medicine
- Sleep studies
- GU medicine
- Paediatrics
- Paediatric cardiology
- Paediatric endocrinology
- Paediatric gastroenterology
- Paediatric respiratory Medicine
- Neurosurgery
- Level 1, 2 and 3 neo-natal intensive care (three separate services)
- Radiotherapy
- Chronic fatigue syndrome/ myalgic encephalopathy (ME)
- Staff nursery
- Sexual health clinics
- Neuchal screening
- Step down for discharge
- HDU for respiratory medicine
- Private patients
- Rehabilitation

Appendix 2 List of Governors' Events

Event name	Date	Location
Career Option Day	19 April 2018	Sweyne Park School, Sir Walter Raleigh Drive, Rayleigh SS6 9BZ
High School Careers Day	24 April 2018	St. Bernard's High School, Bernadine Hall, Milton Road, Westcliff-on-Sea SS0 7JS
Career Option Day	25 April 2018	Greensward Academy, Greensward Lane, Hockley SS5 5HG
Jobs Fair	26 April 2018	Seevic & Palmer's College, Runnymede Chase, Benfleet SS7 1TW
Launch of the BAME Diversity Network Group and recognise the seventh NHS Equality, Diversity and Human Rights Week	21 May 2018	Lecture Theatre, Southend University Hospital NHS Foundation Trust
Careers Fair	27 June 2018	Cecil Jones Academy, Eastern Avenue, Southend-on-Sea SS2 4BU
Skills event for Southend Schools	4 July 2018	Park Inn Hotel, Church Road, Southend-on-Sea SS1 2AL
Meet the professionals	6 July 2018	Lecture Theatre, Southend University Hospital NHS Foundation Trust
Project 49 birthday event	13 July 2018	Garon Park, Southend-on-Sea
Careers Fair	18 July 2018	Highlands Blvd, Southend-on-Sea, Leigh-on-Sea SS9 3TG
AGM	26 September 2018	Lecture Theatre, Southend University Hospital NHS Foundation Trust
South Essex College Fresher's Fair	4 October 2018	South Essex College of Further & Higher Education, Southend Campus, Luker Road, Southend-on-Sea SS1 1ND
Careers Event for Y11	29 November 2018	Southchurch High School, Southchurch Blvd, Southend-on-Sea SS2 4XA
Careers Event	11 January 2019	The Deanes Academy, Daws Heath Road, Thundersley, Benfleet SS7 2TD
Careers Fair	13 February 2019	Chase High School, Prittlewell Chase, Westcliff-on-Sea
Worker Governors' Listening Exercise	25 February 2019	Education Centre Lobby, Southend University Hospital NHS Foundation Trust
Careers Fair	7 March 2019	St Thomas More High School, Kenilworth Gardens, Westcliff-on-Sea SS0 0BW
Mock Interviews	22 March 2019	The King John School, Shipwrights Drive, Thundersley, Hadleigh, Benfleet SS7 1RQ
CAVS Community Breakfast	28 March 2019	Runnymede Hall, Kiln Road, Thundersley SS7 1TF
Meet the professionals	29 March 2019	Lecture Theatre, Southend University Hospital NHS Foundation Trust

Appendix 3 Glossary

BAF	Board assurance framework
Block Contract	A value of Clinical Income agreed between the Commissioner and the Trust and included in the Heads of Terms between the organisations
CAC	Clinical assurance committee
Care bundle	check list with a number of points to be monitored on a regular basis
CAS	Central Alerting System
C-diff	Clostridium difficile
CEMACE	Centre for Maternal and Child Enquiries
CEMACH	Confidential Enquiry into Maternal and Child Health
CETV	Cash equivalent transfer value
CIP	Cost improvement programme
CLRN	Comprehensive local research network
CNS	Clinical nurse specialist
CNST	Clinical Negligence Scheme for Trusts
Control Total	An Income & Expenditure target issued to Trusts by NHSI. The target is expressed as a final net surplus or deficit and the value excludes any income from fixed asset donations and any profit or loss from asset disposals
COPD	Chronic obstructive pulmonary disease
Core brief	Monthly meeting designed to cascade important information throughout the organisation
CoSRR	Continuity of service risk rating
CQC	Care Quality Commission
CQUIN	Commissioning for quality and innovation - a financial reward framework which encourages quality improvement and innovation to bring health gains for patients, e.g. achieving reduced levels of infection
DAHNO	Data for head and neck oncology
Dashboard	Dashboard reports are high level, easy to read reports giving a 'snapshot' of the overall performance of an organisation, department or chosen area
DIPC	Director of infection prevention and control
DVT	Deep vein thrombosis
EBITDA	Earnings before interest, taxes, depreciation and amortisation
EBUS	Endobronchial ultrasound
EDS	Equality delivery system
EoE SHA	East of England Strategic Health Authority
ENT	Ear, nose and throat
EPP	Emergency patient pathway

EQ-VAS	A score recorded by an individual for their current health-related quality of life
Executive team	The Trust's chief executive, director of nursing, chief financial officer, medical director, director of operations and director of and organisational development and human resources
FSRR	Financial sustainability risk rating
FT	Foundation Trust
GDH	Glutamate Dehydrogenase
Grade 3 pressure ulcer	Full thickness skin loss
Grade 4 pressure ulcer	Extensive destruction with possible damage to muscle, bone or supporting tissues
GRR	Governance risk rating
HCA	Healthcare assistant
HCAI	Healthcare associated infection
HMSR	Hospital standardised mortality ratio (relative risk of death)
HROD	Human resources organisational development
ICNARC	Intensive Care National Audit and Research Centre
IOSH	Institute of Occupational Safety and Health
IP	Intellectual property
IPR	Integrated performance review
IST	Intensive Support Team
KPI	Key performance indicator
LD	Learning disabilities
LINAC	Linear particle accelerator
MHRA	Medicines and Healthcare products Regulatory Agency
Monitor	Until 31 March 2016, this was the organisation that authorised NHS Foundation Trusts and was the regulator for health. From 1 April 2016, this is now NHS Improvement
MRI	Magnetic resonance imaging (a type of scan)
MRSA	Meticillin-resistant staphylococcus aureus
MSK	Musculoskeletal
MSSA	Meticillin-sensitive staphylococcus aureus
NAS	Neonatal abstinence syndrome
NHS Improvement	This is the organisation that superseded Monitor and the NHS Trust Development Agency from 1 April 2016
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIV	Non-invasive ventilation

NPEU	National Perinatal Epidemiology Unit.
NPSA	National Patient Safety Agency
O&G	Obstetrics and gynaecology
OH	Occupational health
OJEU	The Official Journal of the European Union is the publication in which all tenders from the public sector which are valued above a certain financial threshold according to EU legislation, must be published
OPD	Outpatients department
PALS	Patient advice and liaison service
PbR (Payment by Results)	A national tariff which is applied to the activity performed by a Trust to arrive at their Clinical income
PDSA	Plan, do, study, assess
PET	Positron emission tomography, or patient experience tracker
PMO	Project management office
PPH	Post-partum haemorrhage
PROMS	Patient reported outcome measures
PSF	Provider Sustainability Fund – replaces the STF in 2018/19
PTL	Patient Tracking List - A list of patients who need to be treated by given dates in order to start treatment within maximum waiting times set out in the NHS Constitution
QAC	Quality assurance committee
QIA	Quality impact assessment
QIPP	Quality, Innovation, Productivity and Prevention (now called System Reform)
QRP	Quality and risk profile
RCA	Root cause analysis
RCOG	Royal College of Obstetricians and Gynaecologists
SEPT	South Essex Partnership University NHS Foundation Trust
SFI	Standing financial instruction
SHMI	Summary hospital-level mortality indicators report mortality at trust level across the NHS in England using standard and transparent methodology
SHOT	Serious hazards of transfusion
STF	Sustainability & Transformation Funding - The term given to funding that the DoH has available to facilitate the sustainability of services in the short-term and the transformation of them in the longer-term
TDM	Therapeutic drug monitoring
TIA	Transient ischaemic attack