NHS
Mid and
South Essex
NHS Foundation Trust

Mid Essex Hospital Services

NHS Trust

Annual Report and Accounts

for the year ended **31 March 2020**

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Performance Report

Overview – a word from our chair and chief executive

The 2019/20 year has truly been unprecedented. We faced the COVID-19 pandemic in the final quarter of the year (the effects of which will be with us well into the 2020/21 year) and we successfully completed the merger of the three acute trusts in Mid and South Essex to form a new organisation on 1st April 2020 – Mid and South Essex NHS Foundation Trust (MSE).

Before we proceed with this final annual report and accounts for Mid Essex Hospital Services NHS Trust (MEHT), we want to pay tribute to our staff, those in front-line clinical roles and the clinical support and corporate staff on whom they depend, including our cleaners and domestic staff, porters, security and maintenance teams. Over the years, our team have stepped up on so many occasions to provide high quality care for patients but the dedication and commitment shown during the pandemic has been truly exceptional and we thank each and every one of them.

Care Quality Commission (CQC) Inspections

In March 2020 the CQC published their report following the inspection conducted at Broomfield Hospital in November and December 2019. Whilst the Trust continued with a "Requires Improvement" rating, compared to the previous 2018 report there had been a marked improvement and in the categories of effective, caring and well led the outcomes were "Good". The CQC's report identified the safe and responsive criteria which required improvement. However, four of our six core services were rated as "good" overall. Details of how MEHT has responded to the recommendations of the CQC for the remainder of 2019/20 and how the merged trust will continue to do so can be found in the Annual Governance Statement.

Our partner trusts also underwent CQC inspections during the year. Both SUHT and BTUH retained their overall ratings of "Requires Improvement" and "Good" respectively. We were pleased that all three trusts were rated as "Good" for Well Led, Effective and Caring. The CQC reports highlighted many areas of good practice at each hospital, particularly at MEHT where significant steps forward were noted since the previous inspection).

The new trust will have an overall rating of "Requires Improvement" on 1st April 2020. We are in discussions with the CQC about the right time for them to undertake a review of the new organisation so that we can improve upon this rating.

Improving services for patients

During 2019/20, our Group of three trusts, (hereafter referred to as "the MSE Group"), delivered on a number of changes to clinical services in line with our commitment to the population of Mid and South Essex that our commissioners consulted upon during 2017/18. Highlights of phase one are summarised below.

In early December 2019, the Interventional Radiology hub became fully operational at Basildon Hospital, providing a 24 hours a day, 7 days a week service.

In January 2020, we commenced the transfer of cardiology services from Broomfield Hospital to Basildon Hospital. This project has been initiated as a pilot over the winter 2019, in order to make better use of bed capacity whilst evaluating the potential benefits of a consolidated service, with 7 day consultant cover.

Phase one of orthopaedic clinical reconfiguration has seen the reconfiguration of spinal elective inpatients to Southend from Basildon, as well as the extension of choice to low-risk patients requiring a Hip and Knee replacements to receive their surgery at Braintree Community Hospital. This is resulting in lower waiting times for patients.

Phase one vascular reconfiguration of emergency vascular services at Basildon, became operational in March 2020. This will improve patient outcomes by consolidating specialist vascular surgeons on a single site as a centre of excellence.

Phase 2 of the clinical changes was due to commence during the first quarter of 2020/21. However these changes will be delayed due to the impact of COVID-19. The planned phase 2 schemes include:

- Consolidation of spinal day case activity alongside elective inpatient activity that was reconfigured in phase one.
- Further development of the Braintree orthopaedic elective centre to take more complex hip and knee replacement patients.
- Consolidation of vascular elective aortic aneurysm repairs at Basildon.
- Implementation of the recurrent cardiology model between Basildon and Broomfield Hospitals following the pilot in phase 1.
- Ensuring a long term solution for the provision of ophthalmology day case procedures that were consolidated for a period of one year, as an enabler to phase one reconfiguration.

Phase 3 implementation of changes was planned for implementation in the second half of the 2020/21 year, subject to the duration of the pandemic.

Providing care during the COVID-19 pandemic

Notwithstanding the flow of patients with a confirmed COVID-19 diagnosis, and also staff infections with the virus, the Trust was not overwhelmed and was able to provide continuing care within planned increased capacity.

The pandemic illustrates clearly the tangible benefits of operating as a single, large new trust bringing together all of our hospitals and staff. We have been able to co-ordinate our resources, including bed space, clinical supplies such as ventilators and personal protective equipment, and of course, our staff to provide seamless care through much more resilient clinical services.

Recognising that managing a public health emergency of this scale cannot be undertaken by one sector alone, the MSE Group implemented a range of measures to protect patients, visitors and staff. Further details can be found in the Annual Governance Statement (page 39).

The country remains under significant restrictions to minimise the spread of COVID-19. Through our well-tested major incident management processes, we will continue to adapt our response to balance the need to safeguard our staff, patients and visitors, with the need to transition safely to restore levels of service, particularly the resetting of elective inpatient and outpatient care. Readers can be assured that the safety and wellbeing of our patients and staff will always be paramount in any decisions we take.

Financial position of MEHT and the MSE Group

We are pleased to be able to report that, pre-COVID related adjustments, all three trusts in the MSE Group delivered their control totals for the year and therefore full Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) monies were achieved by the organisations. Overall as a system, the control total has been delivered for 2019/20. This does not detract from the challenge of 2020/21, however this is a positive outcome to a challenging 2019/20.

At the start of 2019/20 control totals were agreed by each of the trusts in our Group. The MEHT control total was £47.2m inclusive of PSF, FRF and MRET central funding.
Mid Essex Hospitals reported throughout the year a forecast which met this control total position and finished the year meeting this expected financial position.

Operational performance

Regrettably, this year has seen all of the trusts in our Group achieving below the standards set out in the NHS Constitution for access to services. This replicates the picture across the majority of acute trusts in the UK.

The reasons for this are complex and all of our trusts were on trajectory for delivering significant improvement in operational performance this year. However COVID-19 significantly impacted upon our achievement of these standards as we cancelled non-urgent elective inpatient work and outpatient appointments so that clinical time could be focussed upon caring for patients affected by the pandemic.

A summary of the three trusts' performance against the principal NHS Constitution standards is shown in the table alongside.

Readers should note that, for operational reasons, MEHT was exempted from national reporting requirements for RTT during 2019/20. This means that we are unable to report against this standard as an MSE Group. Reporting against RTT for the merged trust is expected to include data from the Mid Essex sites during 2020/21.

Constitutional Standard	Target	BTUH 2019/20 average	MEHT 2019/20 average	SUHT 2019/20 average	MSE Group 2019/20 average
4 hour maximum wait in A&E	95%	89.4%	79.0%	80.8%	83.6%
Referral to Treatment Times (RTT) – 18 weeks in aggregate, admitted patients	90%	66.9%	Dispensation not to report	52.7%	Cannot calculate MSE Group figure due to MEHT dispensation not to report
Referral to Treatment Times (RTT) – 18 weeks in aggregate, non-admitted patients	92%	76.4%		87.4%	
Referral to Treatment Times (RTT) – 18 weeks in aggregate, incomplete pathways	92%	69.3%		78.8%	
Cancer 62 day waits for first treatment (from urgent GP referral)	85%	74.9%	60.9%	65.5%	66.3%
Cancer 62 day waits for first treatment (from NHS Cancer Screening Service referral)	90%	63.2%	59.9%	89.1%	70.7%
Cancer 2 week wait (all cancers)	93%	94.0%	82.6%	93.3%	89.7%
Cancer 2 week wait (breast symptoms)	93%	87.2%	55.8%	96.6%	79.8%
Diagnostic – 6 week wait	99%	97.9%	92.0%	88.1%	92.9%

Creating a new organisation

Readers will be aware that our Trust has been formally working in ever closer collaboration with our partner acute trusts (Basildon and Thurrock University Hospitals NHS Trust – BTUH and Southend University Hospital NHS Foundation Trust - SUHT), collectively known as the MSE Group, for over four years. In January 2018, the Boards of the three trusts decided to pursue a merger to create a brand new organisation which would help us to deliver the clinical changes, as well as taking a significant step to resolving the longstanding financial deficits in the Mid and South Essex NHS.

Between January 2018 and March 2020, we developed a Merger Strategic Case, a Merger Business Case, a Patient Benefits Case and a Post Transaction Integration Plan (PTIP). These documents, were assessed in detail by our main regulator, NHS Improvement (NHSI) against statutory requirements to ensure that a merger was the right move for patients, staff and taxpayers.

NHSI approved the merger to take effect from 1st April 2020, assigning the transaction an "amber" risk-rating overall. This means that NHSI were satisfied that the merger was safe and in the interests of patients, staff and taxpayers, although there were a number of issues that arose from their detailed review that the enlarged trust will need to address the financial and operational challenges, and to deliver the full range of benefits from the merger.

There will be enhanced reporting and monitoring arrangements between the new trust and NHSI, however discussions as to the form and frequency of these will take were deferred until the resolution of the COVID-19 pandemic. We look forward to working closely with NHSI to provide them, our Board of Directors and our Governors with the necessary assurance to resolve these outstanding issues.

Our new Board of Directors

The Board of Directors for the Mid and South Essex NHS Foundation Trust was appointed through an open competitive process led by Governors of the two predecessor Foundation Trusts alongside representatives of the Patient Council of MEHT.

Nigel Beverley was honoured to be appointed as Chair of the merged Trust. Following Nigel's appointment, 8 non-executive directors were appointed by Governors, in line with target skill sets that they determined. The non-executive team comprises a positive mix of those who served on the Boards of the predecessor trusts and those with experience and skills gained outside the local acute sector, achieving a balance between fresh insight and perspectives and corporate memory at board-level.

Goodbye and Thank You

On 31st March 2020, we said goodbye and thank you to all except one of the non-executive directors who played a significant role in the governance of MEHT, in the collaborative arrangements with our partner trusts and in ensuring that the new organisation would be safe from day one and would bring the benefits that we set out in our submissions to NHSI.

Our thanks and best wishes are extended to Karen Hunter, Colin Grannell, Parm Phipps, Jill Stoddart and David Wilde.

It is only right that we formally thank the Governors of BTUH and SUHT, and the Patient Council Leaders of MEHT, for their commitment, support and respectful challenge during the merger preparation process.

For over two years, the Governors and Patient Council Members have participated in a wide range of meetings, discussions and conferences where critical issues of governance and of patient experience were developed in an equal partnership between the Governors, Patient Council members, Board members and senior officers. Amongst the tangible outcomes of this work were key aspects of the Trust Constitution. These included the public membership constituencies, composition of the Council of Governors, agreement of the target skill sets for non-executives and ultimately the appointment of the Trust Chair and the eight non-executives for the new Board, which followed a process where all three trusts had an equal voice.

The dedication of the Governors and Patient Council Leaders is further shown by their willingness to continue to fulfil their roles in an informal capacity for the new trust until the elections for the MSE Council of Governors takes place. This interim measure will help us to uphold the spirit of the Foundation Trust legislation in terms of accountability to members and to the wider public. We hope that many of the former Governors and Patient Council members will remain with us and stand for election to the MSE Council of Governors or to the MSE patient experience infrastructure.

Closing remarks

The 2019/20 annual report reflects a truly unprecedented final year for our Trust. The local, group-wide and national strategic and operational challenges throughout the year, as described in this annual report have tested our business continuity planning to the greatest extent experienced for many years. We have all seen by the public response to the pandemic how much the herculean efforts of NHS staff to deliver the best care possible to patients in extremely difficult circumstances is appreciated by the Board, our communities and the nation as a whole. We look forward to the first year of Mid and South Essex NHS Foundation Trust in pursuit of the goals of the Mid and South Essex Health and Care Partnership to build future which is clinically and financial sustainable for the long term.

Clare Panniker
Chief Executive

24 June 2020

Alan Tobias OBE
Chair, MEHT

24 June 2020

Overview - going Concern statement

After taking into account all relevant factors, the Board has determined that the accounts should be prepared on a going concern basis for the year ended 31st March 2020 based on the following factors:

In March 2020, NHS Improvement (and Secretary of State for Mid Essex Hospital NHS Trust) approved the acquisition of the Trust, along with Basildon and Thurrock University Hospital NHS Foundation Trust by Southend University Hospital NHS Foundation Trust and for the combined organisation to be subsequently known as Mid and South Essex NHS Foundation Trust. Following that decision, the Board had a clear and fixed intention for the acquisition to proceed on 1 April 2020 and that there was no reason to believe that this would not be achieved.

The predecessor trusts had submitted a joint financial plan for the financial year 2020/21 and main commissioners had supported the acquisition proposal and the continuation of previously agreed contracts.

As directed by the GAM 2019/20, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. In that respect, all of the services provided previously by Mid Essex Hospital Services NHS Trust have now been taken on and are being provided by Mid and South Essex NHS Foundation Trust, and these services will continue to be delivered using the same assets as acquired from the Trust.

Overview - statement of purpose and activities of the Trust

Trust profile and history

MEHT has been providing planned and emergency healthcare to more than 380,000 people living in and around Chelmsford, Maldon, Witham and Braintree since it became an NHS Trust in 1992.

It also provided a county-wide plastics, head and neck, and upper gastrointestinal surgical service to 3.4million people, and a supra regional burns service which covers a population of 9.8million.

The Public Finance Initiative funded hospital wing at the front of Broomfield Hospital opened in 2010, and meant the trust could centralise the vast majority of services on one site. In 2014 it took over the running of clinical services at Braintree Community Hospital.

In the year the trust continued to work towards a merger with Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust with the clear strategic priorities of:

- Being a single, well-led, high performing and innovative organisation which joins up care for the people we serve.
- Delivering high quality, safe and responsive services shaped by best practice and our local communities.
- Being an employer of choice for a supported, engaged and high-performing workforce.
- Being effective and efficient with all our resources, creating an organisation that residents and staff can rely on for the long-term.

A Chief Executive and Executive team jointly covering the three organisations was in place, along with a site management team covering our Trust on a day-to-day operational basis.

The Mid Essex Trust Board remained separate in the year, made up of Non-Executive and Executive Directors, and met jointly with the equivalent Boards of the Basildon and Southend trusts. This allowed the Boards to remain separately accountable for the performance of each organisation, but promoted a joint approach as we moved towards the merger.

We worked closely with local partners to provide high quality healthcare for the population of Mid Essex. We were also a member of the Chelmsford Local Strategic Partnership and had strong links with Chelmsford, Maldon, Braintree and Uttlesford local authorities.

We had very close ties with Anglia Ruskin University – we worked jointly on clinical training and research projects - which were cemented with the opening of its Medical School in 2018.

We had a good relationship with the Clinical Commissioning Groups, and particularly Mid Essex CCG, and continued to support initiatives with voluntary organisations and the Department of Work and Pensions to offer apprenticeships, work placements and supported employment opportunities.

The Mid and South Essex Sustainability and Transformation Partnership, of which the Trust formed part, continues to bring together all local stakeholders to deliver proposals – including the merger of the three trusts – which will improve health and care for our communities.

Our Services

The Trust provided an extensive range of acute healthcare services for the population of central, eastern central and northern central Essex. These were provided from the primary site at Broomfield Hospital in Chelmsford and the sites at St Peters, Maldon and Braintree Community Hospital.

The Trust provided county wide services in plastic, gastro intestinal and head and neck surgery and an internationally recognised burns service for the County, region and world-wide.

Accountability Report

Directors' Report

The directors are responsible for the preparation of the annual reports and accounts and they consider the annual report and accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients and other stakeholders to assess the Trust's performance, business model and strategy. They are also responsible for meeting Parliament's key accountability requirements. The corporate governance report, as below, outlines the composition and organisation of the governance arrangements within the Trust.

The Directors' Register of Interests, which was updated annually, was available on the Trust website at https://www.meht.nhs.uk/about-us-/about-the-trust/

Corporate Governance Report

Composition and completeness of the Board of Directors

The Remuneration Committees in Common considered the composition, skills, balance and completeness of the Trust Board and was satisfied that the Board's composition was appropriate for the leadership of the Trust during 2019/20.

How our trust was run

The Trust was run by the Board of Directors, who were collectively responsible for the quality of healthcare delivery and financial performance. The Board of Directors were held to account for stewardship of public money and delivery of services by NHS England and NHS Improvement. The Board of Directors was held to account for quality of services by the Care Quality Commission (CQC).

Leadership

The chairman was responsible for leadership of the Board of Directors.

As chairman of the Board of Directors, the chairman ensured the Board's effectiveness and set its agenda. The chairman facilitated the effective contribution and performance of all Board members who collectively were responsible for the Trust's long-term success and sustainability. The Chairman also ensured that there was sufficient and effective communication with stakeholders to understand their issues and concerns.

The role of the Board of Directors

The Board of Directors set the strategic direction of the Trust ensuring that the necessary financial and human resources were in place to meet its priorities and objectives. It operated within a framework of processes, procedures and controls which allowed performance and progress to be monitored and its risks carefully assessed and managed.

The Board of Directors was responsible for ensuring compliance with mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations. Details of how the Board of Directors discharged its duties with regard to governance and compliance can be found in the Annual Governance Statement.

The Board of Directors was responsible for promoting effective dialogue between the Trust and the local community on its plans and performance, ensuring that the plans are responsive to the community's needs.

The chief executive is ultimately responsible for implementing the strategy agreed by the Board and for developing the Trust's objectives through leadership of the executive team. She recommended to the Board any investment or new business opportunities which promote achievement of this strategy. The chief executive also ensured that the Trust's risks were adequately addressed and appropriate internal controls are in place.

Details of how the Chief Executive ensured that risks are adequately controlled and mitigated can be found in the Annual Governance Statement.

The Trust could hold contracts in its own name and act as a corporate trustee. In the latter role, the Board is accountable to the Charity Commission for those funds deemed to be charitable.

Providing support to directors

Directors were supported by a professionally qualified trust secretary. The trust secretary throughout 2019/20 was James Day.

Newly appointed directors received a tailored induction on joining the Board of Directors.

The Board of Directors ensured that directors, especially the non-executive directors, had access to independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors or to provide additional assurance on areas of challenge. The trust secretary facilitated access to this advice and support.

Directors also had access, at the Trust's expense, to training courses and materials that were consistent with their individual and collective development programme.

How the Board of Directors operated

The Trust maintained its support for the Nolan Principles of Public Life and continued to make the majority of its decisions at Board meetings in public. To support this the Directors Responsibilities and Code of Conduct applying to all directors was adopted by all Board members. This Code of Conduct builds on the NHS Code of Conduct and includes the Nolan Principles. Significant breaches of the Code of Conduct are handled under the Trust's Conduct and Capability Policy.

The Board of Directors approved a policy on Meeting the Requirements of the Fit and Proper Person Test. This policy required the chair to ensure that 'appropriate checks' have been undertaken in reaching a judgement that all directors are deemed to be fit and that none meet any of the unfit criteria. This applied to all members of the Board of Directors, including the Trust secretary. The remit of this policy was expanded during 2017/18 to encompass the site leadership teams and again in 2018/19 to reflect new guidelines from NHSI. This policy enabled the Trust to meet the relevant provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout 2019/20, the MEHT Board met in common with the Boards of Southend and Basildon Trusts on ten occasions, six of which incorporated sessions in public.

The Board of Directors conducted 'walkabouts' where executive and non-executive directors visited clinical areas on the day of the board meetings or site governance forums.

The Scheme of Reservation and Delegation detailed what type of decisions were to be taken by the Board and which decisions were to be delegated to management by the Board of Directors. These were reviewed by the Finance Committees in Common and the Joint Working Board in 2018/19.

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

Collaborative Governance Framework

In December 2016, the Boards of Directors of the three acute trusts in mid and south Essex 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 Health and Care Partnership, whilst remaining three separate and sovereign statutory organisations.
The joint working agreement came into effect on 1st January 2017.

The Boards agreed to create a 'committees 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 took 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, the JWB would be disbanded. Instead, 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 public in February 2019.

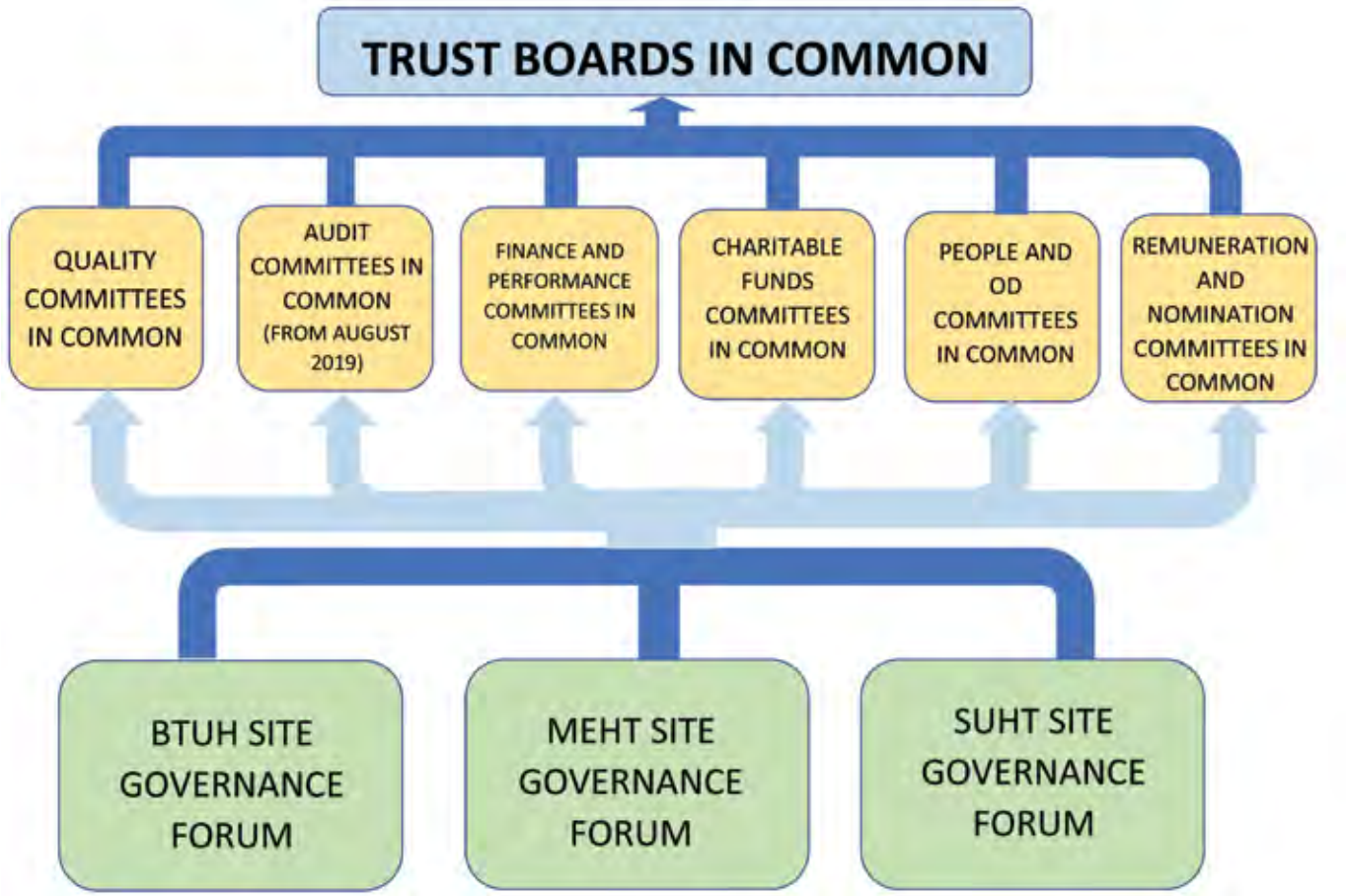
The Trust Boards also decided that the quality committees and the finance and performance committees of each Trust should meet only in common from January 2019. In view of the fact that workforce recruitment and retention was consistently a significant risk for all three trusts, the Boards decided that a new people and organizational development (POD) committee should be created as a committee of each Trust. The POD committees meet only in common.

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 had sufficient opportunity to scrutinise performance of their respective trusts, each organisation had a Site Governance Forum (SGF). These comprised 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 were able to escalate issues to the Committees in Common on an exception risk- basis. Equally, the Committees in Common could refer particular matters for oversight by the relevant SGF. Following each SGF meeting, small groups of site directors and Board members undertook "walkabouts", visiting clinical and corporate areas of the Trust, listening to patients and staff and feeding their comments and urgent actions back to the SGF and the Board.

The Boards decided that the Trust Audit Committees would continue to meet separately, at least until the approval of the 2018/19 annual report and accounts, given their pivotal role in ensuring that each organisation has an effective system of governance, internal control and risk management. At this point, the Oversight Committee was formally abolished and the Audit Committees began meeting in common only.

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

The key elements of the collaborative governance framework in operation across 2019/20 were as shown in the following diagram:



The Board of Directors

The Trust Board managed the Trust. It was made up of executive directors, who were full time employees and non-executive directors, who were members of the local community and who are appointed on a part time, fixed term basis by NHS Improvement.
The Board consisted of five executive and six non-executive directors, including the Chair and Chief Executive.

In the year the Non- Executive Directors were:

- Alan Tobias OBE (Chair)
- Colin Grannell
- Karen Hunter
- Parm Phipps
- Jill Stoddart
- David Wilde

Executive Board Members

The Chief Executive, Clare Panniker, was appointed in April 2016 and was also the Chief Executive at Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust.

Additionally, the voting Executive Directors were:

- Chief Finance Officer – James O'Sullivan (to 2nd September 2019). Dawn Scrafield (from 2nd September 2019)
- Chief Medical Officer – Dr Celia Skinner (to 30th June 2019). Dr David Walker (from 3rd October 2019)
- Chief Nursing Officer – Diane Sarkar
- Chief Strategy and Transformation Officer and Deputy Chief Executive – Tom Abell

As at 31 March 2020 (and the dissolution of the Trust upon merger), the Trust Board consisted of:

- Chairman - Alan Tobias OBE
- Chief Executive - Clare Panniker
- Chief Finance Officer - Dawn Scrafield
- Chief Medical Officer – Dr David Walker Chief Nursing Officer - Diane Sarkar
- Chief Strategy and Transformation Officer and Deputy Chief Executive - Tom Abell
- Chief Nursing Officer – Diane Sarkar

Non-Executive Directors

- Colin Grannell
- Karen Hunter
- Parm Phipps
- Jill Stoddart
- David Wilde

The Executive non-voting members were:-

- Managing Director – Jane Farrell
- Chief Information Officer – Martin Callingham

- Chief Estates and Facilities Director – Eamon Malone
- Chief Human Resources Director – Danny Hariram
- Chief Commercial Officer – Jonathan Dunk

Appointment of Chair and Non-Executive Directors for the new organisation

The Trust had in place arrangements covering the process for the appointment of the Chair and Non-Executive Directors

In the early part of the year, the Council of Governors of SUHFT met with the Council of Governors of BTUH and representatives from the Patient Council of MEHT and agreed that a partnership approach would be adopted whereby the Chair and NEDs appointment decisions for the new organisation would be taken “in common”. The Councils of Governors agreed a plan to have all members of the merged board in place by February 2020 to ensure a smooth transition from the predecessor Board to the Board of the new organisation.

From June 2019 onwards, all meetings of the SUHFT Search and Appointment Committee and Council of Governors related to appointment of the Chair and the NEDs were attended by the representative members of the BTUH Council of Governors and MEHT Patient Council.
After careful consideration by the Council of Governors in common the following key decisions were made:

- a skills audit would be undertaken and the skills set required for the new Board set out to ensure the board would be balanced in terms of skills and experience;
- the Chair and NED positions would be open to application from Chairs and NEDs of the existing trusts and the open market;
- existing NEDs previous terms of office would not be counted in terms of the maximum length of service with the new organisation;
- if appointed, an existing NED would have a term of office of two years followed by a second term of three years subject to satisfactory performance and approval by the Council of Governors;
- newly appointed NEDs would have a term of office of three years followed by a second term of three years subject to satisfactory performance and approval by the Council of Governors;
- an external search firm would be commissioned to facilitate and provide independent advice to Governors on the Chair and NEDs appointment process;
- the job description and person specification would be reviewed by the Search and Appointment Committee;
- preliminary interviews would be conducted by the external search firm;
- the Search and Appointment Committee would select a short list of candidates and recommendations to the Council of Governors who would appoint the Chair and Non-Executive Directors;
- selection would be entirely based on merit assessed through a standard process of application form/CV, panel interview, stakeholder session and references;
- the Chair of the new organisation would be appointed to first and would subsequently be involved in the appointment of the NEDs;
- the remuneration of the Chair and NEDs will be based on benchmarking report for similar size NHS organisations

Following a thorough process based on the aforementioned key decisions, the Council of Governors was delighted to appoint Nigel Beverley as Chair of the Mid and South Essex NHS Foundation Trust. The Council of Governors at subsequent meetings also approved the

appointment of Alan Tobias OBE, Margaret Pratt and Barbara Stuttle CBE (from the existing NEDs pool across the three Trusts), Lynsey Cross, Dave Hughes, Julie Parker, Deepak Singh and Caroline Stanger as NEDs of the new organisation. These appointments took effect from 1 April 2020.

Counter Fraud

During the year the trust continued to work with counter fraud specialists to promote the awareness of fraud and how to report it. A number of investigations were carried out during the year and reported to the Audit Committee. A self-assessment was made against a reporting framework developed by NHS Protect and work was carried out during the year to improve Trust practices.

Directors Register of Interests

The Trust maintained a formal Register of Directors' Interest. The Register was available for inspection, on request, at Broomfield Hospital, Broomfield, Chelmsford, Essex, CM1 7ET.

Compliance with cost allocation

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

Details of any political donations

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

Better payment practice code

The Better Payment Practice Code required 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 1.

Table 1: Performance against Better Payment Practice Code

	2019/20 Volume	2019/20 Value £'000	2018/19 Volume	2018/19 Value £'000
NHS – Paid in Year	2,776	30,560	2,612	22,305
NHS – Paid within Target	2,049	23,054	1,434	13,239
NHS - % paid within Target	73.8%	75.4%	54.9%	59.4%
Non NHS – Paid in Year	91,541	213,505	90,530	211,147
Non NHS – Paid within Target	74,245	189,092	56,020	168,919
Non NHS - % paid within Target	81.1%	88.6%	61.9%	80.0%

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 was 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.

Statement of 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 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 trust's auditor is aware of that information.

Remuneration Report

The Secretary of State has determined that NHS Trusts should disclose certain information in relation to those individuals who are considered to be senior managers by virtue of having significant influence on the major business activities of NHS Trusts. The Chief Executive has determined that the senior managers of the Trust in 2019/20 were the Executive and Non-Executive Directors and other directors who attend Board meetings. The figures in the pension table below were supplied by the NHS Pensions Agency. The salaries and allowances of senior managers in tabular format, table of pensions benefits of senior managers, staff numbers and the pay multiples information have been audited by the Trusts auditors BDOLLP

Remuneration Committee

The remuneration policy for Executive Directors was set by the Remuneration Committee which is a subcommittee of the Board and met in common with the equivalent committees of the Basildon and Southend Trusts. This Committee in Common was responsible for the appointment and/or dismissal of all Executive Directors as well as the approval of their remuneration, terms of service and the monitoring of their performance. It was chaired by the Joint Board Chairman and all Non-Executive Members of the Board were entitled to sit on the committee. The Chief Executive and Chief People and Organisational Development Director attended the committee as requested to advise on matters relating to other Executive Directors and the performance of the Trust.

Executive Directors Remuneration Policy

Executive Directors were appointed through open competition by members of the Remuneration Committee in Common. All Executive contracts are permanent and have a six month notice period. No contracts have provisions for compensation for early termination. The policy on remuneration of Executive Directors is in line with the Department of Health guidelines.

Senior managers pay progression is subject to achievement against corporate objectives. They are assessed against performance measures set during the appraisal process. A regular report to the Board, which updates the progress on the corporate objectives is used by the remuneration committee in common to assess whether the senior managers performance conditions have been met.

Non-Executive Directors Remuneration Policy

The Chairman and Non-Executive Directors were appointed to the Trust by NHS Improvement. They were appointed for terms of up to four years with a maximum total of two terms being permissible before the post was subject to external advertisement. A maximum of ten years was permissible with one organisation.

Table 2: Senior managers and Non-Executive Remuneration 2019/20 (subject to audit)

			Year ended 31 March 2020					
			Salary	Expense Payments	Annual Performance related bonus	Long-term performance related bonuses	All pensions related benefits	Total
			(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
			£'000	£'	£'000	£'000	£'000	£'000
Executive Directors								
Clare Panniker	Chief Executive		80 - 85	100	-	-	-	**80 - 85**
Tom Abell	Chief Transformation Officer		50 - 55	100	-	-	37.5 - 40	**90 – 95**
Martin Callingham	Chief Information Officer		40 - 45	100	-	-	30 - 32.5	**75 - 80**
Dawn Scrafield	Chief Financial Officer	From Sep 2019	30 - 35	100	-	-	30 – 32.5	**60 - 65**
David Walker	Chief Medical Officer	from Oct 2019	35 - 40	0	-	-	-	**35 - 40**
Eamon Malone	Chief Estates & Facilities Director		45 - 50	2,700*	-	-	30 - 32.5	**75 - 80**
J. O'Sullivan	Chief Financial Officer	Until Sep 2019	20 - 25	100	-	-	12.5 – 15	**35 -40**
Danny Hariram	Chief People & Organisational Development Director		60 – 65**	100	-	-	-	**60 - 65**
Diane Sarkar	Chief Nurse		45 - 50	100	-	-	27.5 - 30	**75 - 80**
Jonathan Dunk	Chief Commercial Officer		50 - 55	0	-	-	25 – 27.5	**75 - 80**
Dr Celia Skinner	Chief Medical Officer	Until July 2019	15 - 20	-	0 – 5***	-	0	**20 - 25**
Jane Farrell	Managing Director		170 - 175	200	-	-	72.5 – 75	**245 - 250**

** includes one-off relocation expense package*
***includes one-off pensions payment due to issues identified in the prior year*
**** relates to clinical excellence award*

Non - Executive Directors

				Salary	Expense Payments	Annual Performance related bonus	Long-term performance related bonuses	All pensions related benefits	Total
				(Bands of £5,000)	(To nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
				£'000	£'	£'000	£'000	£'000	£'000
A. Tobias OBE	Chair			40 - 45	200	-	-	-	**45 – 50**
C Grannell	Non - Executive Director			15 – 20	400	-	-	-	**20 - 25**
P Phipps	Non - Executive Director			10 - 15	-	-	-	-	**10 - 15**
K Hunter	Non - Executive Director			10 - 15	100	-	-	-	**10 – 15**
J. Stoddart	Non - Executive Director			5 - 10	200	-	-	-	**15 - 20**

Table 3: Executive Directors DISCLOSURE 2019/2020 (subject to audit)

		Year Ended 31 March 2020			
		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
Executive Directors					
Clare Panniker	Chief Executive	245 - 250	80 - 85	80 - 85	80 - 85
Tom Abell	Chief Transformation Officer	155 - 160	50 - 55	50 - 55	50 - 55
Martin Callingham	Chief Information Officer	130 - 135	40 - 45	40 - 45	40 - 45
Dawn Scrafield	Chief Financial Officer (from Sep 2019 – present)	90 - 95	30 – 35	30 – 35	30 - 35
David Walker	Chief Medical Officer (Oct 2019 – present)	115 – 120	35 – 40	35 – 40	35 - 40
Eamon Malone	Chief Estates & Facilities Director (from Dec 2018 – present)	135 - 140	45 - 50	45 - 50	45 - 50
J. O'Sullivan	Chief Financial Officer (Feb 2017 – Aug 2019)	65 - 70	20 - 25	20 - 25	20 - 25
Danny Hariram	Chief People & Organisational Director (from Nov 2018 – present)	190 - 195	60 – 65	60 – 65	60 - 65
Diane Sarkar	Chief Nurse	145 - 150	45 - 50	45 - 50	45 - 50
Jonathan Dunk	Chief Commercial Officer (from May 2018 – present)	150 – 155	50 - 55	50 – 55	50 – 55
Dr Celia Skinner	Chief Medical Officer (from Feb 2017 – Sep 2019)	60 - 65	20 - 25	20 - 25	20 - 25
Jane Farrell	Managing Director	170 - 175		170 - 175	

Table 4: Senior managers and Non-Executive Remuneration 2018/19

			Year Ended 31 March 2019							
			Salary	Expense Payments	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
Executive Directors										
Clare Panniker	Chief Executive		75 - 80	600	-	-	-	-	62.5 – 65.0	**140 – 145**
Tom Abell	Chief Transformation Officer		50 - 55	200	-	-	-	-	85.0 – 87.5	**135 – 140**
Martin Callingham	Chief Information Officer		40 - 45	400	-	-	-	-	-	**40 – 45**
John Henry	Director of Environment and Infrastructure	Sep 2018 to Dec 2018	5 - 10		-	-	-	-	12.5 – 15.5	**20 – 25**
Mary Foulkes OBE	Chief Human Resources Director	Until Nov 2018	25 - 30	-	-	-	-	-	52.5 - 55.0	**80 – 85**
Danny Hariram	Chief People & Organisation Development Director	From Nov 2018	15 - 20	200	0	0	-	-	0	**15 - 20**
Paul Kingsmore *	Director of Environment and Infrastructure	from December 2017 to Sept 2018	25 - 30		-	-	-	-	-	**25 – 30**
J O'Sullivan	Chief Financial Officer		50 - 55	-	-	-	-	-	45.0 – 47.5	**95 – 100**
Jonathan Dunk	Chief Commercial Officer	From May 2018	40 - 45	400	-	-	-	-	172.5 - 175	**215 - 220**
Eamon Malone	Chief Estates & Facilities Director	From 4 Dec 2018	10 - 15						7.5 - 10	**20 - 25**
Diane Sarkar	Chief Nurse		45 - 50	-	-	-	-	-	7.5 - 10	**55 - 60**
Dr Celia Skinner	Chief Medical Officer		60 - 65		-	-	-	10 - 15	30 - 32.5	**105 – 110**
J Farrell	Managing Director	From 16 July 2018	120 - 125	100	-	-	-		-	**120 - 125**
Dorothy Hosein	Managing Director	Until 1 July 2018	40 - 45	-	-	-	-	-	-	**40 -45**

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

Non - Executive Directors

				Salary	Expense Payments	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			0 – 5	-	-	-	-	-	-	0 - 5
Nick Alston	Non - Executive Director			30 – 35							30 – 35
C Grannell	Non - Executive Director			10 - 15	400	-	-	-	-	-	10 – 15
P Phipps	Non - Executive Director			10 – 15	-	-	-	-	-	-	10 – 15
K Hunter	Non - Executive Director			10 – 15	100	-	-	-	-	-	10 – 15
J. Stoddart	Non - Executive Director			5 - 10	600	-	-	-	-	-	5 - 10
David Wilde	Non - Executive Director			5 - 10	-	-	-	-	-	-	5 -10

Table 5: Executive Directors DISCLOSURE 2018/2019

			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
Executive Directors						
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
John Henry	Director of Environment and Infrastructure	Joint Executive Group	25 – 30	5 - 10	5 - 10	5 – 10
Mary Foulkes OBE	Chief Human Resources Director	Joint Executive Group	75 - 80	25 - 30	25 - 30	25 - 30
Danny Hariram	Chief People & Organisational Development Director	Joint Executive Group	50 - 55	15 - 20	15 - 20	15 - 20
Paul Kingsmore	Director of Environment and Infrastructure	Joint Executive Group	75 - 80	25 - 30	25 - 30	25 - 30
J O'Sullivan	Chief Financial Officer	Joint Executive Group	160 – 165	50 - 55	50 - 55	50 - 55
Jonathan Dunk	Chief Commerical Officer	Joint Executive Group	130 - 135	40 - 45	40 - 45	40 - 45
Eamon Malone	Chief Estates & Facilities Director	Joint Executive Group	40 - 45	10 - 15	10 - 15	10 - 15
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
J Farrell	Managing Director (from 16 July 2018)	Joint Executive Group	120 - 125	-	120 - 125	-
Dorothy Hosein	Managing Director (until 1 Jul 2018)	Joint Executive Group	40 - 45	-	40 - 45	-

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 6a: Pension entitlement for senior managers 2019/20 (subject to audit)

		Year ended 31 March 2020						
		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 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020
		(Bands of £2500)	(Bands of £2500)	(Bands of £5000)	(Bands of £5000)			
Executive Directors								
Clare Panniker*	Chief Executive	-	-	-	-	0	-	0
Tom Abell	Chief Transformation Officer	2.5 - 5.0	0 - 2.5	25 - 30	0 - 5	236	15	268
Martin Callingham	Chief Information Officer	2.5 - 5.0	0 - 2.5	55 - 60	135 - 140	1,085	42	1,172
Dawn Scrafield	Chief Financial Officer	0 - 2.5	0 - 2.5	50 - 55	105 - 110	673	21	746
David Walker*	Chief Medical Officer	-	-	-	-	-	-	-
Eamon Malone	Chief Estates & Facilities Director	2.5 - 5	0	0 - 5	0	12	17	49
J. O'Sullivan	Chief Financial Officer	0 - 2.5	0	15 - 20	0	233	15	295
Danny Hariram	Chief People & Organisational Development Director	2.5 - 5	0 - 2.5	40 - 45	90 - 95	629	0	704
Diane Sarkar	Chief Nurse	2.5 - 5.0	0	50 - 55	115 - 120	907	30	980
Jonathan Dunk	Chief Commercial Officer	0 - 2.5	0	35 - 40	65 - 70	458	12	503
Dr Celia Skinner***	Chief Medical Officer	0	42.5 - 45	0	0	1958	n/a**	n/a**
Jane Farrell	Managing Director	2.5 - 5	12.5 - 15	70 - 75	220 - 225	1,664	n/a**	n/a**

**These individuals have opted out of the pension scheme in 2019/20*
*** Due to scheme retirement ages for C Skinner and Jane Farrell no CETV values are available for disclosure*
**** relates to clinical excellence award*

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 6b: Pension entitlement for senior managers 2018/19

		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
		(Bands of £2500)	(Bands of £2500)	(Bands of £5000)	(Bands of £5000)			
		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Executive Directors								
Clare Panniker	Chief Executive	2.5 - 5.0	5.0 - 7.5	70 - 75	175 - 180	1,393	192	1,160
Tom Abell	Chief Transformation Officer	5.0 - 7.5	0 - 2.5	20 - 25	0 - 5	236	61	149
Martin Callingham	Chief Information Officer	0 - 2.5	0	50 - 55	135 - 140	1,085	92	947
John Henry	Chief Estates & Facilities Director	0 - 2.5	0 - 2.5	15 - 20	45 - 50	366	24	263
Mary Foulkes OBE	Chief Human Resources Director	2.5 - 5.0	2.5 - 5.0	15 - 20	30 - 35	321	68	235
Danny Hariram*	Chief People & Organisational Development Director	0	0	0	0	0	0	0
J. O'Sullivan	Chief Financial Officer	2.5 - 5	0	10 - 15	0	233	49	159
Jonathan Dunk	Chief Commercial Officer	7.5 - 10	20 - 22.5	30 - 35	65 - 70	458	154	258
Eamon Malone	Chief Estates & Facilities Director	0 - 2.5	0	0 - 5	0	12	5	0
Diane Sarkar	Chief Nurse	0 - 2.5	0	45 - 50	110 - 115	907	89	774
Dr Celia Skinner	Chief Medical Officer	2.5 - 5	7.5 - 10	85 - 90	260 - 265	1,958	208	1,668
Jane Farrell	Managing Director from 16 July 2018	0	0	65 - 70	200 - 205	1,664	0	1,191
Dorothy Hosein	Managing Director until 1 July 2018	0	0	0	0	0	0	0

*** 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.*

Reporting of relationship between highest paid and median remuneration

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

The banded remuneration of the highest paid director in the Trust in the financial year 2019/20 was £160k-£165k (2018/19, £165k-170k). This was 7 times (2018/19, 6) the median remuneration of the workforce, which was £24k (2018/19 £29k).

	2019/20 £000s	2018/19 £000s
Band of Highest Paid Directors Total Remuneration	160 - 165	165 - 170
Median Total Remuneration	24	29
Ratio	**7**	**6**

In 2019/20 and 2018/19, total remuneration was calculated on an annualised basis, using the actual pay scale of all staff. It includes salary and non-consolidated performance-related pay, but not severance payments. It does not include employer pension contributions, and the cash equivalent transfer value of pensions, or benefits-in-kind.

In 2019/20, 14 employees received remuneration in excess of the highest-paid director (2018/19, 25). Remuneration ranged from £17k to £255k (2018/19, £17k - £240k). This is based on actual salary and allowances paid to employees (rather than on the annualised basis described previously), but not severance payments, employer pension contributions, and the cash equivalent transfer value of pensions, or benefits in kind.

Clare Panniker
Chief Executive

22 June 2020

Staff Report

Staffing Information

An analysis of the Trust's staff costs and staff breakdown is 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 7: Analysis of staff costs (subject to Audit)

	2019/20			2018/19		
	Total £000	Permanent £000	Temporary £000	Total £000	Permanent £000	Temporary £000
Salaries and wages	**186,379**	186,379	-	**171,363**	171,363	-
Social security costs	**18,096**	18,096	-	**16,530**	16,530	-
Apprenticeship Levy	**912**	912	-	**842**	842	-
Employer's contributions to NHS pensions	**28,993**	28,993	-	**18,740**	18,740	-
Pension cost – other	-	-	-	-	-	-
Other post-employment benefits	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-
Temporary staff - External Bank	-	-	-	-	-	-
Temporary staff – Agency/Contract	**21,667**		21,667	**25,329**	-	25,329
Total gross staff costs	**256,047**	**234,380**	**21,667**	**232,804**	**207,475**	**25,329**
Recoveries in respect of seconded staff to Other NHS bodies	-	-	-	-	-	-
Total staff costs	**256,047**	**234,380**	**21,667**	**232,804**	**207,475**	**25,329**

Table 8: Number of Staff Employed - by staff group and Role - as at 31 March 2020 (subject to Audit)

Staff group	Headcount	FTE
Nursing and midwifery	1575	1399.42
Medical and dental	602	577.84
Additional clinical services	999	880.69
Allied Health Professionals	196	170.59
Professional scientific and technical	146	129.54
Healthcare scientists	109	102.19
Estates and ancillary	526	388.10
Administrative and clerical	991	861.00
Total	5144	4509.38

** data provide by ESR*

Table 9: Number of filled Bank and Agency roles - by staff group - as at 31 March 2020

staff group	FTE
Nursing and midwifery	301.13
Medical and dental	78.01
Additional clinical services	161.20
Allied Health Professionals	0.00
Professional scientific and technical	43.59
Healthcare scientists	0.00
Estates and ancillary	65.01
Administrative and clerical	61.27
Grand total	710.21

** data provide by Finance*

Table 10: Gender Split as at 31 March 2020

	Male	Female
Directors	9	7
Other senior managers	30	57
Employees	1106	3949
Total	1137	4007

Table 11a: Sickness percentage as at 31 March 2020

staff group	% Absence Rate
Nursing and midwifery	4.07%
Medical and dental	1.12%
Additional clinical services	5.81%
Allied Health Professionals	2.57%
Professional scientific and technical	3.64%
Healthcare scientists	1.81%
Estates and ancillary	9.87%
Administrative and clerical	4.52%
Trust total	4.50%

** data provide by ESR - Average of 12 months 2019-20 Financial Year*

Table 11b: Sickness data as at 31 March 2020

Measure	Value
Average full time equivalent (FTE) April 2019 to March 2020	4,350
FTE-days available	1,573,385
FTE-days lost to sickness absence	70,814
Average of 12 months (2019-20 Financial year)	4.50%
Average sick days per FTE (include long term sickness)	16

** data provide by ESR*

Equality and Diversity

The Trust has an overarching equal opportunities in employment policy which underpins the work the Trust has been doing throughout the year with regard to Equality, Diversity and Inclusion. The strategic aims of Equality, Diversity and Inclusion were monitored and progressed through the Equality, Diversity and Inclusion Group, (this Group was successfully launched across MSE in 2019), to ensure that the Trust met not only its statutory duties, but also best practice and had real focus for delivery, for the forthcoming year.

Examples of initiatives undertaken during 2019-2020 included the creation and the development of successful diversity network groups at the Trust. The network groups which were launched during 2019/20 comprised of; Armed Forces and their Families, BAME, LGBTQ+, Disability and Faith and Belief. Each Network Group had annual objectives to achieve, which are agreed and reviewed with their members and are aligned to the Equality, Diversity and Inclusion Group objectives. Each Network Group had established a profile during 2019-2020 and provided our staff with a voice at many events and celebrations throughout the year. Such campaigns and events held during 2019-20 where all staff were encouraged to participate included:

- Celebration of Black History Month (events included a conference, film evening and social media campaign)
- Wear it Red Against Racism Day
- National Rainbow Badge Campaign (championing LGBTQ+ agenda)
- Attending Gay Pride Events at both London and Southend
- Launch of the Disability Passport
- Celebration of International Women's Day

The groups played an active contribution to the Equality, Diversity and Inclusion Group (EDIG) and were part of the overall agenda. The Trust continued to focus on promoting the networks, to ensure the promotion of inclusion for all groups. Following the extremely successful International Women's Day event (where celebratory events were held across MSE including external speakers) we will be launching a Gender Equality Network Group during 2020 across MSE. Representatives from the Trust were also invited to attend parliament for the NHS Confederation International Women's Day conference which was extremely well received.

This Gender Equality Network Group will focus on championing gender equality and through initiatives, will contribute to the reduction and elimination of the Gender Pay Gap over the forthcoming years. The Armed Forces and their Families Group is extremely well supported at the Trust and championed by the Senior Leadership Team, with the Armed Forces Covenant in place, recognising the partnership with the Armed Forces within the local community, which the Trust represents. During the year, the Trust received the Ministry of Defence Silver Award within the Employer Recognition Scheme.

Promotion of the equality and diversity agenda continued as part of the Trust Welcome Days. MSE have a rolling diversity calendar of events where we hold celebrations and are part of community events throughout the year which staff at MEHT were encouraged to actively participate in. Equality and Diversity Training was also provided for all staff including newly qualified and overseas nurses throughout the year. This training is mandatory.

The Trust continued 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 was reflected in the Equality Diversity and Inclusion overall action plan which incorporated the Workforce Race Equality Standard (WRES), Workforce Disability Standard (WDES) and Equality Delivery System 2 (EDS2). We should be mindful however that these reports have been suspended for the remainder of 2020.

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.

The Gender Pay Gap report was uploaded to the national database and published on our internet site prior to 30th March 2020. The report demonstrated 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 were 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.

A link to the Gender Pay Gap report is provided below:

https://www.meht.nhs.uk/about-us-/equality-and-diversity/gender-pay-gap-report-msb-group-btuh-meht-suhft/

Table 12: Gender Pay Gap

Details of the gender pay gap are available on the attached link above. However a summary of the key data is provided below for ease. An action plan is also provided on the relevant link and these action plans are consistent across the MSE Group:

Measure	Percentage
Mean Pay Gap	28.49%
Median Pay Gap	8.42%
Mean Average Bonus Pay Gap	39.93%
Median Average Bonus Pay Gap	50.00%
Proportion of Males Receiving a Bonus Payment	8.79%
Proportion of Females Receiving a Bonus Payment	0.68%

Further to the successful pilot in 2017, the Trust continued to engage the Guardian Service during 2019-20 to support the Freedom-to-Speak-Up agenda. This 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 was supported by a Freedom-to-Speak-Up steering group, which was attended by representatives from the Trust including nominated Speak-Up Champions from each directorate, which further promoted the agenda.

The Guardian Service attended various staff forums to promote the service and ensure that staff can access. There was 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.

Policies

As part of the planning for merger, the following policies had been developed, agreed and were in place for the new merged organisation. A Joint Policy Development Working Group comprising of representatives from Staff-Side, Operational Management and Human Resources professionals working in partnership from across the legacy three Trusts was set to take forward the policy development work. The group will continue to work through all human resources policies until there is a single set of policies for the new organisation. These will be:

- Appeals Policy
- Attendance Policy
- Bullying and Harassment Policy
- Disciplinary Policy
- Family Friendly Policy
- Flexible Working
- Grievance Policy
- Home Working
- Leave Policy
- Managing Organisational Change
- Performance Improvement Policy
- Probation Policy
- Redeployment Procedure
- Workforce Investigations Policy

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

Actions taken in the financial year to consult employees or their representatives on a regular basis so that views of employees could be taken into account in making decisions which are likely to affect their interest

In addition to the local Joint Consultative Negotiating Council, there was also an MSE Joint Negotiating Council, chaired by the Chief People and Organisational Development Director. This brought together trade union representatives, human resources professionals and operational managers to consult with and discuss proposed changes for the Trusts' employees, working together to provide the best experience for staff.

Communication with employees

Communication through Chief Executive and Executive Group member briefings sustained communication about merger plans, clinical redesign and corporate services redesign programmes. The monthly emails from the Chief Executive and weekly local bulletins highlighted key management and operational messages to staff. The Site Leadership Team members continued to visit wards and departments to talk to staff and hear their successes and concerns.

1Week, the weekly Trust-wide bulletin, ensured staff across all three sites received key information, vacancy details and shared success stories consistently and at the same time.

Standard communication channels included regular executive briefings at Core Brief, Friday Round Up, daily Moving Forward morning briefings, Connect magazine and staff emails.

Involvement in performance

The Trust informed staff of its performance on a regular basis, through its communication channels including Moving Forward@Mid daily briefings and monthly Core Brief presentations. Feedback through divisional meetings and Moving Forward@Mid briefings was sought. Moving Forward@Mid daily briefings and monthly Core Brief were open to all staff, and formed the basis of local team briefings. Staff were encouraged to give feedback on their views regarding performance through local team briefings.

Consultation with employees

In line with the merger plans and service redesign, the trust commenced the review and was supported by the single group organisational change policy and redeployment procedure, ensuring a consistency to the approach to change through a single merged process across the three legacy sites. The trust also put into place a change management team who worked very closely with our Trade Union partners, and supported corporate managers with their structural changes, again ensuring consistency in process and approach to change.

Occupational Health and Wellbeing 2019

It is essential that our staff are safe, with access to a range of facilities and services to promote the health and wellbeing of our workforce. The Occupational Health and Wellbeing service is one of the MSE Group corporate services functions across the sites with one management structure. The principles were replicated across the sites and enable the same core functions, ensuring consistency across the Group. Following implementation of an updated IT system, core functions are now streamlined and staff could access any site, regardless of their place of work, with all staff being able to access the services offered.

The health and wellbeing strategy aim is to offer consistency across the Group, including access to physiotherapy, lifestyle/wellbeing initiatives and access to Occupational Health practitioners for assessment and signposting for in-house and external support and agencies. The service worked with the staff engagement team and communications strategy in promoting national health and wellbeing initiatives. It also produced guidance and support for managers and staff; to recognise and signpost staff who would benefit from the various health and wellbeing initiatives.

Services available:
Activity clubs
Carers Support
Diversity Network Groups
In-house self-refer physiotherapy
Discounted gym access
Health Checks
Hospital choir
Schwartz rounds
Stress Management Training
The Guardian Service
Pastoral Care
MHFA Training and Network
Recognition and rewards
Smoking Cessation
Healthy lifestyle advice
Alternative commutes
The annual flu campaign achieved an uptake of 57.7%.

Counter-fraud and bribery arrangements

It is essential that proper use is made of public money and the Trust was and is committed to high ethical and moral standards. To this end the Trust took 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 had procedures in place that reduced the likelihood of bribery occurring which included 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. The Trust was 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 was 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 included a Disciplinary policy and procedure, Anti-Fraud and Anti-Bribery policy and Raising Concerns at Work (Whistleblowing Policy). The Trust had a local counter fraud HR protocol, commissioned by NHS Protect, which was reviewed and renewed annually.

Organisational Development

Organisational development aimed to enable staff to make a positive difference for patients through culture change, engagement and learning in a sustainable and systematic way. The function was part-merged in 2016/17 to a Group function and 2019/2020 saw investment and significant consolidation of the OD role to support merger. Work included Board support for adoption of the NHSI/E Compassionate Leadership Programme and at the start of the “Discovery phase”, where senior leaders attended the Staff College leadership development training and corporate teams were supported through the three into one merger with team and individual development. Induction and statutory and mandatory training was streamlined and harmonised and through the Organisational Development, education and learning function, an apprenticeship strategy was created as well as delivering high quality student nurse induction and training, clinical skills development (Simulation) and professional knowledge services (Libraries).

2019 NHS Staff Survey

The NHS Staff Survey is conducted annually. Consistent with previous years, the Trust elected to conduct a full survey, providing the opportunity for all staff to participate. The Survey was conducted between 8 October and 29 November 2019 by our contractor Quality Heath.
The 2019 response rate results are shown in Table 24.

Table 13: Response rate

	2016	2017	2018	2019
% Response	37%	33%	33%	50%
No of responses	449	1519	1496	2380

Headline Results

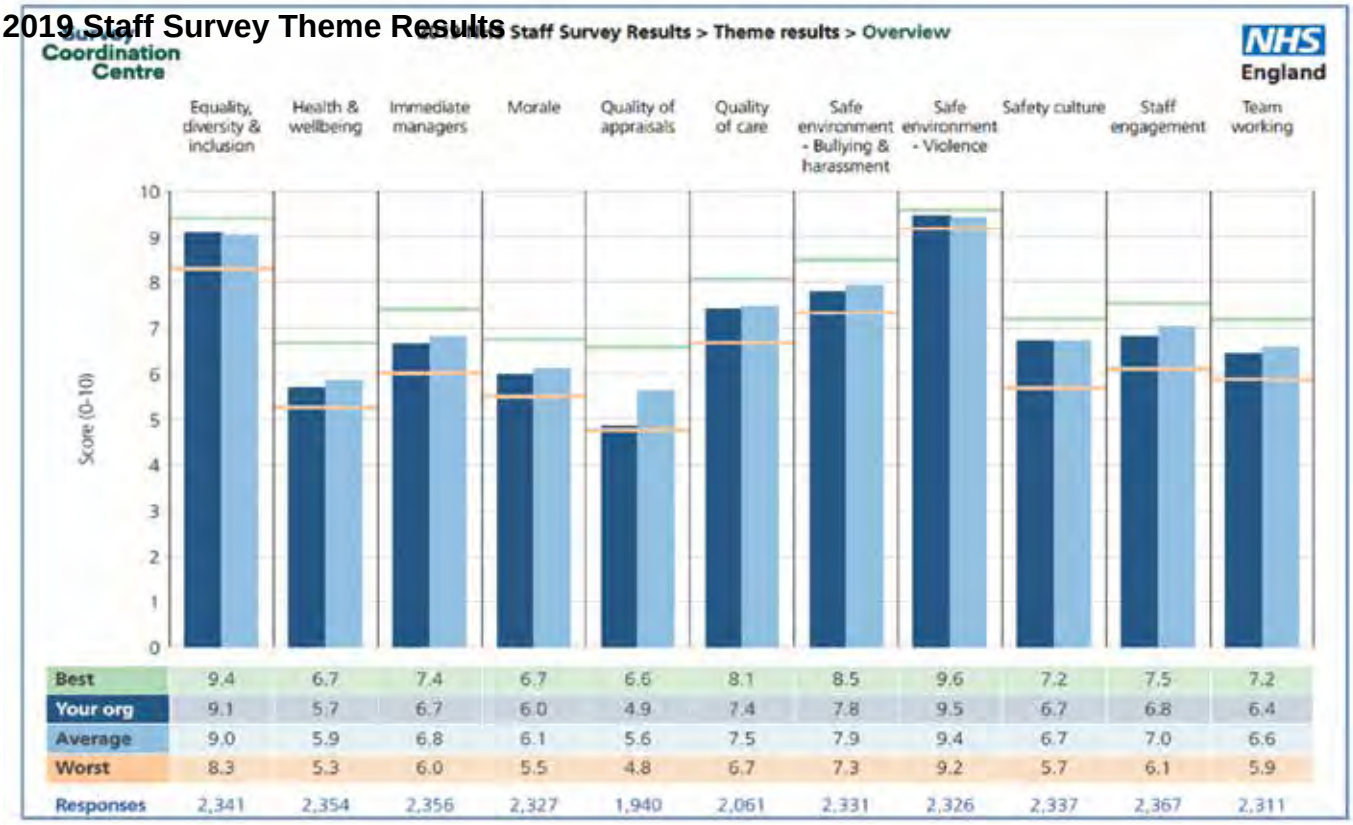
- The Trust increased its percentage of responses by 17% to reach 50% completion rate
- The Trust response rate was above the Acute Trust Average ("ATA") of 46%
- The results demonstrated the Trust scores remained similar to last year with some improvement. Our key theme strength remained 'Safety Culture' and our key areas of concern remained as health and wellbeing, bullying and harassment, morale and quality of appraisals.

The trust saw improvement in 6 out of 11 key themes since 2018 including staff morale, health and wellbeing, the quality of care our staff feel able to provide and the support our staff receive from managers.

The Trust met or exceeded the NHS ATA in three categories: equality and diversity, patient safety and the confidence to report near miss or incidents and a reduction in incidents of violence.

The structure of the NHS Staff Survey has changed and there are no longer key findings. These have been replaced by 11 Themes. The overall scores for these 11 Themes for the Trust are shown on the next page.

2019 Staff Survey Theme Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.1	5.7	6.7	6.0	4.9	7.4	7.8	9.5	6.7	6.8	6.4
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,341	2,354	2,356	2,327	1,940	2,061	2,331	2,326	2,337	2,367	2,311

Future priorities and targets

1. As part of the Culture Change Programme diagnostic phase, the trust reviewed in depth the feedback given by and work with Directorate/Division and department leads to ensure their current 2019-2020 action plans reflect the most recent feedback and their plans aim to address the priorities in their area.

2. The trust continued with the 2019-2020 Action Plans addressing the key issues arising in the 2018 and 2019 Staff Survey in the 6 priority areas identified previously. These were:

- To attract and better retain a greater number of our staff (Recruitment Action Plan);
- To improve staff health & wellbeing, in particular their resilience (Occupational Health Action Plan);
- Building on our current work around respect & dignity (Equality & Diversity Action Plan);
- To continue to develop our diversity & inclusion agenda (Equality & Diversity Action Plan);
- To improve the quality of the appraisal process (Culture Change Programme plan); and
- To continue with our on-going management and leadership development programmes (Culture Change Programme plan).

3. We mapped where appropriate actions and initiatives with the planned work within the Culture Change Programme 2020-2021 to avoid duplication.

4. The trust explored the intervention needed in hotspot areas identified via the diagnostic process and recommended next steps.

Communication

5. We continued to engage with staff to encourage their contribution via the survey and ensure they feel this contribution is valued and will inform current and future change programmes and actions. We did this by:

- Engaging with Staff Survey Site leads, our Unions and Directorate/division leads to support the updating or realignment of Directorate/Division action plans;
- Publishing Group and local action plans via our 'We Said We Did Intranet' Hubs at each hospital to ensure transparency with staff;
- Providing bi-monthly updates on the progress of these plans via email to all staff;
- Engaging with our workforce via Staff Survey 'road show' style events at each site in March 2020. These events provide staff with the opportunity to comment, provide feedback and submit ideas and suggestions on alternative or additional actions we can take.;
- Monitoring progress of the Staff Survey Group Action Plan via the OD Programme Board reporting to POD CIC. Accountability at Directorate level for delivery was via regular monitoring of Directorate plans by HR Business Partners, reporting to Site Leadership teams.

6. Developing a joint MSE campaign for the 2020 Staff Survey aimed at securing a 60% response across all three sites.

The results from the NHS Staff Survey 2019 were published by NHS Staff Survey Coordination Centre on 18 February 2020. The following reports were circulated on Thursday 13 February 2020:

- Staff Survey Summary of Results Report together with full breakdown of individual question results for the Group.
- Directorate/division summary reports detailing all individual question results by directorate/division
- PowerPoint presentations outlining the Group, Trust and directorate/division results including top and bottom scores, recommendations and forthcoming engagement events. These will be provided to directorate/division leads and HR Business Partners for dissemination at department team meetings.
- WRES and WDES results presentations.

Monitoring of progress

- Monitoring of progress of our Action Plans was via Divisional Performance Review Meetings, Site Leadership team and with oversight by the Senior Management Group. Accountability at Directorate level for delivery was via regular monitoring of Directorate plans by HR Business Partners, reporting to the Site Leadership team.

The Trade Union (Facility Time Publication Requirements)

Table 14: Relevant Union Officials

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

Table 15: Percentage of time spent on facility time

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

Table 16: 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: (total cost of facility time ÷ total pay bill) x 100	*0.009359*

Table 17: 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%

Expenditure on consultancy

The total expenditure on consultancy for the financial year was £1.6m (2018/19 £2.7m). Consultancy costs reduced, however, the on-going transformation and efficiency initiatives undertaken by the Trust required specialist consultancy support during the year.

Off payroll arrangements

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

Table 18: For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2020	1
Of which...	
No. that have existed for less than one year at time of reporting.	-
No. that have existed for between one and two years at time of reporting.	1
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 were subject to a risk based assessment as to whether assurance was required that the individual was paying the right amount of tax and, where necessary, that assurance has been sought.

Table 19: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, 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	0
Of which...	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	-
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 20: For any off-payroll engagement of Board members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

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

Exit Packages 2019-2020

There were two exit packages during 2019/20 (1 in 2018/19).

Table 21: Exit package costs

	2019/20			2018/19
Exit package cost band	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number	Total number of exit packages Number
<£10,000	-	-	-	-
£10,001 - £25,000	-	-	-	-
£25,001 - 50,000	-	-	-	-
£50,001 - £100,000	-	-	-	1
£100,001 - £150,000	-	2	2	-
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exit packages by type	-	**2**	**2**	1
Total resource cost (£)	-	£233,000	**£233,000**	£82,000

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.

Segmentation

Mid Essex Hospital Services NHS Trust was in Segment 3 during the year 2019/20. The description of trusts that fall into Segment 3 is set out in the Single Oversight Framework as follows:

'Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.'

This segmentation was the Trust's position as at 31 March 2020. 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 22: Overall finance score

Area	Metric	2019/20 Scores				2018/19 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	3	4	4	4
	Liquidity	4	4	4	4	4	3	2	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	2	1	1
	Agency spend	4	4	4	4	4	4	4	4
Overall scoring		3	4	3	3		3	3	3

Statement of Directors' Responsibilities in Respect of the Accounts

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

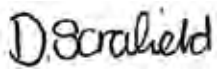
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

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

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

By order of the Board

24 June 2020 Chief Executive 

24 June 2020 Chief Finance Officer 

MEHT Annual Governance Statement 2019/20

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievements of the NHS 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 Trust was administered prudently and economically and that resources were applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

I am accountable to the Chairman of the Trust and have regularly provided performance reports to NHS Improvement and NHS England, which have monitored progress and performance against the NHS Accountability Framework for the year to 31 March 2020.

In order to help maintain internal control, the Trust has also worked with the Mid Essex Clinical Commissioning Group, national and local strategic health bodies and advisers and other health economy partners including community services providers, Essex County Council, and particularly the acute NHS Foundation Trusts at Basildon and Southend of which I am also Chief Executive.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievements of the policies, aims and objectives of Mid Essex Hospital Services NHS Trust, to evaluate the likelihood of these 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 Mid Essex Hospital Services NHS Trust for the year ended 31st March 2020 and up to the date of the approval of the annual report and accounts.

Collaborative governance arrangements

Whilst Mid Essex Hospital Services NHS Trust remained a statutory organisation governed by a Board of Directors holding the fiduciary duties required by legislation, a collaborative governance framework (with a contractual joint venture overlay) was and continued to be in place between the three acute trusts within the Mid and South Essex Sustainability and Transformation Partnership (STP). These trusts are Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust. The Trusts have a shared Executive Management Team and myself as Chief Executive under this arrangement.

Hereafter these organisations will be referred to collectively as "the MSE trusts" or "the MSE Group". Any reference to "the trust" refers specifically to Mid Essex Hospital Services NHS Trust.

In 2019/20 the Trust Boards met only in common, save for exceptional circumstances and a single meeting per year to approve the respective trust's annual report and accounts.

Throughout 2019/20, the Trust Board meetings in common occurred on a monthly basis (alternating between formal meetings and seminars/board development sessions with any formal urgent business).

As a result, the Trust Boards decided to rescind the delegations they made in December 2016 to set up a Joint Working Board .in parallel to separate Trust Boards.

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 created new people and organisational development (OD) committees in common. Recognising the strategic importance of workforce, these committees provide additional capacity and capability to co-ordinate a strategic approach to workforce and OD issues.

The Trust Boards agreed that the three Audit Committees would continue to meet separately until the annual report and governance process had been completed for 2018/19. As a result, the Audit Committees have been meeting in together in common only since August 2019 whilst remaining separate committees of their respective Trusts.

When making these decisions to further integrate our governance arrangements across the Group, the Trust Boards were keen to ensure that the granularity of scrutiny at site-level was not overlooked, recognising the associated risks to internal control and to patient safety that this could present within the current operating mode. As a result, the Trust Boards agreed to create a Site Governance Forum (SGF) within each trust. Whilst the SGFs had no formally delegated authorities from the relevant Board, they provided a platform for the site leadership team to meet with the Trust-specific non-executive directors on a monthly basis to review performance and risks at site-level and to collectively identify solutions. The SGFs also undertook "walkabouts" of the hospital in order to promote ward to board governance.

As illustrated above, the capacity to identify and handle strategic and high level operational risks and to put in place effective controls across the three trusts developed to complement the systems within the individual organisations and hospital sites. The key aspects of the risk and control framework across the MSE 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 Directors Report above.

Capacity to handle risk

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

The Finance and Quality committees in common provided additional capacity to handle risk across the MSE Group. Up until June 2019, the Oversight Committee provided specific capacity to assess and manage the risks and governance challenges associated with the collaborative governance framework under which the three trusts are operating. Over summer 2019, the Oversight Committee was formally disbanded and its responsibilities were adopted by the Audit Committees in Common (see above).

The Future Organisational Form (FOF) Programme Board provided dedicated capacity to identify and handle risks associated with the proposed merger of the three trusts. The FOF Programme Board comprised executive directors (including myself 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 was intended to meet for at least the first three months of the new organisation to provide additional assurance on the strategic and operational risks associated with the transition to the Board of the new trust.

Leadership on risk management was provided by the Board of Directors, through myself 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 2019/20 year was the Chief Nursing and Quality Officer, who also held executive responsibility for risk management across the Group. As such, the Chief Nursing and Quality Officer provided additional capacity to identify risks that related to the strategic objectives of the Group and to put in place system-wide as well as local controls to mitigate those risks. The operational site lead for risk management was the Director of Nursing as part of the site leadership team.

The roles and functions of the executive directors were formally reviewed each year to ensure that there were no gaps or overlays in the corporate management structure of the Trust.

As the joint working and redesign of clinical support, corporate support and clinical services across the Group developed, a number of group-wide leadership roles below executive level have continued to be created in order to provide additional capacity to handle risk in critical and high-risk services. These roles include a Group Director of Cancer Services, a Group Director of Planning and Performance and a Group Chief Pharmacist. The creation of these posts provided a single point of leadership for these services and mitigated the risk of the control framework across the three trusts becoming ineffective as the organisations developed towards the proposed merger.

The role of each executive and site director was 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 were identified and met through personal development plans. Performance against objectives is assessed throughout the year. Formal appraisals were undertaken of the executives by me as Chief Executive.

My formal appraisal was undertaken by the Chairs of the MSE trusts. The outcomes of the executive appraisals (including mine) were presented to the Remuneration and Nomination Committees (RemNoms) of the three trusts meeting in common. The structure of the executive and site leadership teams ensured that appropriate focus was 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 was delegated to the site leadership team in partnership with the divisional leadership teams.

The site leadership team meet weekly and the senior management group, comprising the site leadership team and the divisional leadership teams, met together monthly. There were monthly structured performance and accountability meetings where the divisional and site leadership teams monitored performance and addressed key issues and there was an additional programme of steering group meetings led by myself as Chief Executive which regularly undertook a deep dive analysis of the Trusts performance on a rolling programme. The site leadership team met with the Non-Executive directors in a site governance forum monthly.

During 2019/20, we appointed Group Clinical Directors to provide additional support to the Site Clinical Directors and to ensure appropriate synergies in the clinical pathways between our hospitals as we implemented the clinical service changes about which the public were consulted in 2017/18.

Staff with risk management and advisory responsibilities were employed where appropriate throughout the trust and each maintained the relevant qualifications and experience to ensure that competent advice was available to all managers and staff. A list of advisors was available in the Risk Management Strategy, and included professionals in mergers and acquisitions within the NHS, patient safety, medicines management, fire safety, security, health and safety, clinical risk, law, financial improvement and sustainability, business continuity and emergency planning, operational and patient flow improvement, and transformation of our organisational form.

Together with clinical and non-clinical leads and advisors, these specialists supported the creation, implementation and monitoring of policies, protocols and guidelines for the effective control of risk. Where responsibilities were assigned to individuals within the Risk Management Strategy, the trust reviewed their training needs as part of the annual performance review process to ensure that their competence remained sufficient for the discharge of their duties.

All employees have an important role to play in identifying, assessing and managing risk. To support employees in this role, the trust provided a range of policies, strategy, procedures, protocols and guidelines, together with information at all levels relevant to an individual's role. The trust aimed to ensure that employees had the knowledge, skills, support and access to the expert advice necessary to manage risk efficiently and effectively. Support and training were 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 had a clear policy for staff completion of mandatory and core training aimed at managing risk. The policy was clear that managers were responsible for ensuring staff completion of training. This was monitored regularly and reported to the People and OD committees in common as part of the workforce section of the monthly integrated performance report, to the Site Governance Forum and ultimately to the Trust Boards in Common.

Learning from good practice was encouraged, as was learning from lapses in the standards of care in order to continually strive for better outcomes for patients. Learning was shared internally through team, professional and divisional meetings where clinical practice changes following incidents and complaints were discussed and corporate meetings where risk recommendations from solicitors following inquests or claims were shared. Incident reporting was considered by the Board and its Committees to be a reflection of an open and transparent culture across the organisation.

Risks were moderated by the site leadership team before escalation to the Trust's risk assurance framework, thereby increasing collective understanding and sharing good practice.

The Trust had measures in place to disseminate and act upon alerts and recommendations made by all relevant bodies.

In addition, during 2019/20 the trust maintained a number of communication methods which proved effective and popular with staff.

These included:

- A daily morning "Moving Forward" staff meeting, led by a member of the site leadership team which covers patient safety and performance issues on a division by division basis;

- Weekly safety messages displayed on computer screens and on the trust intranet;
- Divisional patient safety briefings;
- Email briefings from the Managing Director and the Chief Executive;
- “Connect” which is a group-wide magazine launched in January 2019;
- Monthly face-to-face staff briefings;
- Weekly diary emails about highlights of the coming week across the trust;

As the 2019/20 year progressed, these communication methods were harmonised across the Group, with a balance of group-wide and site-specific content.

Learning was shared externally by reporting to organisation 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.

During 2019/20, an MSE Risk and Compliance Group was established which co-ordinated 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, provided additional capacity to handle risk in a co-ordinated way across all three trusts. This methodology has proved successful at site level with a naturally evolving focus towards a group-wide approach since 2018/19.

The risk and control framework

The risk and control framework was designed to manage risk and was continually in place for the Trust in the year to 31 March 2019 and up to the date of the approval of the Annual Report and Accounts. At its core is the governance framework of committees and reporting which underpin the internal control mechanisms.

The Risk Management Strategy is one of the 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 was essential to the trust’s ability to discharge its functions as a partner in the local health and care system, as a provider of health services, as a custodian of public funds and a significant employer. The Risk Management Strategy clearly set out accountabilities for risk management at each level in the organisation and aimed to ensure a comprehensive system of internal control without limiting flexibility and innovation.

The strategy and its associated policies and procedures set out the processes for identifying, assessing, communication, and documenting, escalating, managing and reviewing risks. The effectiveness of the Risk Management Strategy and its implementation was monitored by the Audit Committees in Common. In doing so, the Committees mitigated the risk of failure to comply with the governance expectations of the NHS regulatory authorities and the CQC.

Risks were 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. Additionally risks were identified through the Risk Assurance Framework process at Directorate

and Divisional level and by Executive reviews. Risks were 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.

The key elements of the risk management process, which includes the risks relating to the security and quality of Trust performance information were:

- A risk management strategy and policy reviewed by the Audit Committee and approved by the Trust Board;

- Established procedures at all levels of the Trust in relation to risk management, including a serious incident policy which encourages the reporting of all incidents and issues;

- Trust Board committees meeting in common with non-executive leadership and reporting sub groups with Executive Director leadership tasked with reviewing risk and seeking assurance, including upon the quality of performance information;

- Public/Patient involvement in committees and attendance at Trust Board meetings in common;

- Clear and short management lines for risk management;

- Appropriate risk management training for all staff.

Each division was responsible for managing a risk register which was reviewed by senior managers and risk leads on a regular basis. With effect from the start of 2019/20, the Board Assurance Framework (BAF) became a single MSE group-wide risk management tool. The BAF ensured that the Trust Boards in Common were aware of the highest risks to the achievement of the MSE Group's strategic objectives (which were revised in October 2018) and the controls necessary to ensure that these risks are maintained at an acceptable level. To ensure that the granularity of site-specific operational risks remained subject to appropriate scrutiny, the Site Governance Forum (SGF) reviewed the site corporate risk register on a regular basis, with an escalation route to the relevant committees in common.

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. It is a requirement of the Trust's Risk Management Strategy that the risk appetite is reviewed annually. This approach also accords with the Well Led Guidance published by NHS Improvement, which references regular review of the Board's risk appetite and tolerance as part of evidence that there are clear and effective processes for managing risks, issues and performance.

In September 2019, the Trust Boards in Common formally adopted the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix. Using this tool, a set of group-wide risk appetites were developed and agreed, whilst retaining, for the 2019/20 year, site-specific risk appetites endorsed by the SGFs. The process agreed by the Trust Boards in Common was that any instance where a site may wish to take an action which exceeds the group threshold, this would be escalated to the Executive Team for decision.

As a general principle the Trust had a low tolerance for, and therefore ought to control, all risks which had the potential to:

- Expose patients, staff, visitors and other stakeholders to harm;
- Compromise the Trust's ability to deliver operational services;
- Adversely impact the reputation of the Trust;

- Have severe financial consequences which may impact on the Trust's future viability; and
- Cause non-compliance with law and regulation

The Finance and Performance Committees in Common and the Quality Committees in Common regularly reviewed relevant significant risks and incidents relating to their areas of responsibility.

During 2019/20, we have developed our approaches to Patient Council engagement by participating in a series of four MSE-wide Governor Conferences which were attended by Governors from SUHT and BTUH, and the MEHT Patient Council. These conferences primarily focussed on ensuring that the proposed merged Trust would have optimal corporate governance arrangements from the outset, including developing and approving the Constitution for the new organisation as the Councils of Governors in Common, with the Patient Council as a participating stakeholder. At these Conferences, Governors and Patient Council members also supported the Chief Nursing and Quality Officer in developing her plans for the governance of patient experience in the merged organisation.

As noted above, during 2019/20 the Oversight Committee evolved into an "Audit Committees in Common" model, which provided an additional element of the risk and control framework across the three trusts providing assurance to the Trust Boards in Common.

The most highly rated risks recorded on the BAF during 2019/20 were:

- Failure to achieve and deliver year-on-year improved 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 associated infrastructure is not fit for purposes;

- Failure to develop and fund a long term capital plan which addressed the clinical, estates and technological needs of the organisation;

- Failure to deliver improvement in performance against national performance targets within the agreed trajectories;

- Failure to enable and empower leaders in all areas of the organisation to create a culture of continuous improvement;

- Failure to gain agreement and consensus of our local communities to changes to clinical services that reflect best practice;

- Risk of workforce instability as a result of high levels of turnover and the inability to reduce thee levels, resulting in low staff morale and increased turnover.

The risk profile for the merged trust for 2020/21 is expected to remain broadly similar to 2019/20. COVID-19 will undoubtedly impact upon the merged trust for a substantial part of the 2020/21 year. As such this risk will likely remain on the BAF for the whole year, given that the pandemic will impact on the organisation's ability to deliver services and generally operate once the acute phase has passed.

In preparing the annual reports of each trust within the MSE Group for 2019/20, we have complied with the revised Department of Health and Social Care Group Accounting Manual (GAM) 2019 -20 which was published in April 2020, having been amended by the DHSC to reflect the pressures upon NHS providers during the pandemic. The revised GAM required that we provided more focussed headline coverage of performance across the year. A Quality

Account, with a narrower statute-based scope, will not now be published earlier than 15th December 2020 following recent regulatory changes. The three trusts acknowledge the risk that, having complied with the revised GAM and associated guidance, (and the equivalent for Foundation Trusts), their observance of some of the Nolan Principles of Public Life (particularly Openness and Accountability) may have been compromised. Mitigations include ensuring the operation of a robust Freedom of Information service from day one of the merged trust and, once the national social distancing rules have been lifted, by conducting the business of the board in public. The merged trust will also maintain a relationship with the Governors and Patient Council Leaders from the legacy organisations until the new Council of Governors is in place.

The Trust paid particular attention during 2019/20 to learning from inspections by the Care Quality Commission (CQC). The actions arising from the 2018 CQC inspection improvement plan are now largely complete and work is now underway to address the learning from the most recent inspection by the CQC which took place in November and December 2019. The report was published by the CQC on 6th March 2020. The Trust retained its overall "Requires Improvement" rating but with wide ranging improvements from the previous report. The Trust was rated "Good" for services in the categories of effective, caring and well led, with the latter being an improvement from the previous report. The inspection categories of safe and responsive required improvement. However there was major improvement, particularly in the Medicine division, and four of the six core services were rated as good overall. The ongoing implementation of actions from the CQC report will be monitored by the Quality Governance Committee of the new trust.

Since the beginning of 2019 onwards the Finance and Performance, Safety and Quality , People and Organisational Development and Charitable Funds committees of the three Trusts have remained non-executive director led and have met in common. The committees in common regularly review relevant significant risks and incidents relating to their areas of responsibility including the quality governance arrangements.

The Audit Committee of the Trust remained site based until August 2019 before moving to meeting in Common with the other separate Audit Committee of the other two Trusts. The Audit Committee independently monitored, reviewed and reported to the Board on the extent to which the Trust has in place an effective system of governance, risk management and internal control. The Audit Committee had a key role in assuring the Trust of the validity of its Annual Governance Statement. This was achieved by regular review of the system of internal control and reports from auditors throughout the year and examination of the draft Annual Governance Statement prior to its submission to the Board for adoption. The Audit Committee also reviewed the Board Assurance Framework, (BAF), which documents the risks, controls and related assurances that underpinned the delivery of the Trust's objectives including those relating to the quality of performance information and compliance with CQC registration requirements. The Committee, comprising only of non-executive directors, oversaw the systems of internal control and the overall assurance processes associated with managing risk and has particularly focussed on the Trust financial risk and control mechanisms in the year ending 31 March 2020.

In conducting oversight of the interim governance arrangements introduced to facilitate the response to the COVID-19 pandemic, the Audit Committee, both before and after the merger date, noted and accepted that a number of staff had enabled contacts, or brokered discussions for the trust, with potential PPE suppliers. The committee were satisfied that no purchases were made where our staff had an interest in the supplying entity, but for full disclosure the trust sought declarations of interest where their involvement had been more extensive in facilitating the purchase.

The Trust has a comprehensive process, led by Human Resources, to ensure all executive directors meet NHS Provider Licence General Condition G4 requiring them to be fit and proper

persons to carry out their roles, which is supported by a policy common to the Group.

The principal committees considered their terms of reference during the year, including in the context of the joint working with the Group, and amendments were made to reflect the new joint arrangements, executive and site director attendance and quoracy. The roles and responsibilities of the executive, site directors and committees were clarified and reporting lines and accountabilities were established.

Trust Board and committees, both separately and in Common, have been adequately attended to discharge essential business. There have been no quoracy issues impacting upon the work of the Trust.

The Finance and Performance Committee, meeting in common, was the principal forum for reporting and providing assurance on financial, business and performance issues. It was supported by a sub-structure of reporting groups and departments including those covering investment. It met on a monthly basis. The focus of business in the year remained upon the difficult financial position resulting from increased emergency demand and the cost of maintaining safe staffing levels against shortages.

The Patient Safety and Quality Committee, meeting in common was the principal forum for the assessment of safety, quality, and patient experience across the Trust. It sought and received assurance on governance and risk management, reviewed the Risk Assurance Framework documents from the Trusts and received reports from the relevant executive or site directors in relation to all the areas within its remit. These are contained within the Integrated Quality and Performance report. The committee also received reports on clinical audit, investigations, and learning from experience.

The non-executive director membership of the Trust Board remained unaltered during the year. To enable non executives to remain in a position to discharge their site specific responsibilities, monthly site governance forums were in place since February 2019 to provide the levels of assurance detail not available within the Board and Committees in common schedule.

The Trust retained counter fraud advisors to assist in monitoring its fraud risk and delivering its counter fraud deterrent and investigation profile. This is regularly reviewed by the Audit Committee.

Information Governance Risks and data security risks were managed as part of the risk assessment process and are assessed using the Information Governance Toolkit. There is an Informatics Risk Assurance framework which is reviewed as an integral part of the system of internal control. Risks to data quality and security are continuously assessed and reviewed by the Information Governance Steering Group. The Trust has business continuity plans in place across the organisation and has introduced new data security protocols based upon lessons learned from the previous national cyber- attacks.

The Trust also involved Non- executive directors in board walkabouts to help identify risks in the patient environment and similarly draws upon reports from its Patient Council. Patient story reports have informed Board meetings and site governance forums of potential risk from a patient perspective.

Performance reporting, particularly making best use of the Trust’s electronic patient record system in relation to referral to treatment times and patient access will continue to be a feature of the risk landscape of the merged Trusts in 2020/21. Going forward into 2020/21, it is likely that these risks will remain prominent and there will be emphasis on seeking to reduce risks particularly from emergency demand and bed pressures, RTT challenges, staffing levels and financial deficit.

The above section described the risk and control framework which was in place throughout the 2019/20 year. However the COVID-19 pandemic necessitated a small number of additional measures to ensure that the trust could respond dynamically and proactively to the rapidly changing impact that the pandemic had upon the operation of our hospitals. During March 2020, the focus of our risk and control framework shifted dramatically towards controlling the risk of the virus to patients, visitors and staff, whilst maintaining a minimal "watching brief" on other aspects of clinical and corporate governance and to the management of non-clinical risk. A new risk was crafted as part of the Board Assurance Framework (BAF) of the merged trust to capture the key risks arising from COVID both directly and indirectly. The risk was articulated as "failure to deliver a high quality, safe service for our patients due to the outbreak of COVID-19 and failure to protect our staff from infectious disease transmission".

Temporary modifications to the risk and control framework that were in place from late March 2020 and continued in place up to the date of signature of this Annual Governance Statement. These included:

- the exploration of new and innovative routes for the procurement of personal protection equipment (PPE) for staff and clinical equipment such as ventilators in order to ensure the trust's critical care capacity was as robust and safe for both staff and patients,
- the cancellation of all training and study leave, restrictions on annual leave to free up clinical resources to manage the pandemic
- rapid roll-out of remote working technology to reduce the risk of infection between patients and staff on the hospital sites
- severely limiting visitor access for inpatients to reduce the cross-infection risk
- the postponement of a significant volume of elective surgery and outpatient activity to free up staff and bed capacity and
- establishment of a clinical advisory group comprising senior clinicians to advise the incident management team on use of healthcare resources within the hospital

The Trust Board agreed to consolidate several of its committees into a single "Board Assurance Committee (BAC)" that met once per month in April and May 2020, to balance the risk of taking senior leaders away from operational duties with the risk of inadequate governance during the early months of the merged organisation. As the acute demands from the pandemic began to reduce, the BAC was disestablished at the end of May 2020 and the separate meetings of the committees resumed in June 2020.

Quality Governance

The key elements of quality governance in place during 2019/20 were:

Strategy

The trust has communicated its quality priorities and goals for the year across the organisation and developed its performance information to support the monitoring of progress against these goals. This development of robust performance information is ongoing particularly in the area of referral to treatment, (RTT), where unreliable data in the past has resulted in the Trust continuing to be exempted from national reporting of RTT performance during the year.

A group-wide clinical strategy is in place, supported by a number of enabling strategies and plans. These have been communicated to staff across the trust and formed the basis of business planning activities. The development and implementation of the clinical strategy is overseen the Quality Committees in Common.

Specific and challenging objectives for the Trust and the STP were in place throughout 2019/20 that included key performance indicators, milestones and trajectories. Achievement of these objectives was monitored regularly through the integrated performance report, with supporting benchmarking data (where available) and improvement trajectories.

Capability and culture

Processes were in place to ensure that the Board of Directors has the suitable skills, knowledge and capacity to deliver the trust's objectives and to manage the associated risks. During 2019/20, this information influenced the reorganisation of the portfolios of a small number of Executive Directors. Information about leadership capacity and capability also influenced several substantive and interim appointments to the site leadership team during the year.

Work continued during 2019/20 to maintain the Trust values whilst contributing to the development of an aligned set of values across the Group.

Processes and structure

The Governance team and divisions conducted a number of clinical reviews, using the CQC inspection framework, in order to determine the level of ongoing compliance with the fundamental standards.

During 2019/20, the Trust continued to develop the fortnightly Internal Compliance Action Group (ICAG) introduced the previous year. This meeting brought together key clinical leaders from across the wards and divisions and members of the Governance Team to focus upon a quality and patient safety priorities mapped against the CQC assessment framework. Members of ICAG agreed specific actions which they then implemented immediately in their areas of responsibility.

In order to make its role easier to understand at all levels and across all disciplines, ICAG was renamed the Maintaining High Standards Group.
The ongoing programme of unannounced quality assurance visits, conducted regularly by our commissioners, provided valuable intelligence on the level of compliance with fundamental and professional standards.

During 2019/20 the trust hosted a number of regulatory visits and inspections. These included the Joint Commissioning Team who visited our Maternity and paediatric Services in July and September 2019 respectively. Feedback from both visits was overwhelmingly positive. In June 2019 NHSI conducted an Infection Prevention review and reported that the green internal escalation level had been sustained and in August 2019 the Trauma Network acknowledged the significant progress achieved since the previous visit. In October 2019 the Joint Advisory Group accreditation visit for the Endoscopy service resulted in a deferral for 6 months to allow improvements to be implemented and which were subsequently completed.

A Human Tissue Authority, (post mortem sector), inspection took place in January 2020 and improvements related to changes in the inspection standards are being implemented. Also in January the Royal College of Paediatrics and Child Health quality team reviewed the Children's Diabetic Service raised no serious concerns. In February 2020 Screening Quality Assessment Service (SQAS) Colposcopy visit did raise concerns and the service senior leadership team developed an action plan promptly to address these issues. In February the East of England Critical Care Network peer review provided very positive feedback for the service.

Measurement

The Trust participated in the majority of relevant national clinical audit projects to support benchmarking of services and had an active programme of local audit to support service improvement.

The graphical information provided within the integrated performance reports (received at the Board meetings in public and the Site Governance forum) incorporated the trust's internal quality targets and standards and, where appropriate, benchmarking data to provide clear and transparent information on the trust's performance. Where variances existed, narrative was provided to give assurance that remedial action was being taken to bring performance back within expected parameters.

Benchmarking, wherever possible, took place against other trusts and through the use of national data sets, such as Dr Foster Intelligence, Summary Hospital Mortality indicator (SHMI), Care Quality Commission, National Reporting and Learning System of the National Patient Safety Association and the Quality Observatory. During 2019/20, the use of statistical process control charts (SPCs) was introduced within the integrated performance reports. SPC charts at Board level are recommended by NHSI to facilitate understanding of what is "different" and what is the "norm". By using these charts, Board and their Committees can therefore understand where the focus of work needs to be concentrated in order to make a difference.

Challenge was provided by Board members to the information presented and requests were made for more detailed underlying information in order to identify the root cause of potential issues of concern and emerging trends. Board minutes and arising actions were captured and tracked with action logs. Executives noted sources of information on board and committee reports and ensure independent validation to strengthen assurance, wherever possible.

Documentation of the systems and controls used to produce data for quality and patient safety reports provided assurance about the underlying assumptions to the Board. The Boards in Common, and all of their committees were able to commission external reviews should they have considered additional assurance was required.

Freedom to Speak Up

The Trust had a guardian service which was outsourced to provide assure of independence. The guardian service team attended the staff induction and provided information on who to contact if they have concerns or require support. An escalation agreement was agreed with any patient safety issue being raised to the Director of Nursing or Medical Director. The guardian meets with staff on and off site and supports them to resolution if required. A non-executive director had direct engagement with the guardian service and a monthly discussion with the Director of HR and Nursing and the Guardian service for themes and any further actions took place. A monthly report is shared with the site HR lead. The service continues to be provided in the new Trust.

Never Events

The Trust experienced one never event during 2019/20. In April 2019, a Nasogastric Tube was inserted to support feeding. Checks were not performed correctly and the tube was used before it was recognised that the tube was in the lung rather than the stomach. The patient went on to recover from this incident. However it was identified that locum doctors did not always have access to the Radiology system and that nurse training competency was not always recorded. Details of the never event and points of learning were immediately shared across the Trust and our colleagues at Southend and Basildon Hospitals. The communication included remedial actions to be taken.

Workforce Strategies and Safer Staffing Systems

The Trust is fully aware of the crucial nature of effective workforce planning for the short, medium and long-term. Workforce pressures remain a consistently high-rated risk on both the Trust and the Group Board Assurance Framework and are a focus for Board-level oversight.

The Boards in Common meetings received an overarching safer staffing report on a quarterly basis describing the staffing position across the Group and the pan-trust actions being taken to address any gaps. To ensure that particular local pressures and early warning signs on the sites received prompt attention at Board-level, the trust-specific safer staffing reports were reviewed by the Site Governance Forum. Staffing levels were also reviewed on an ongoing basis as part of the risk management systems and processes described earlier in this Annual Governance Statement.

The Trust Boards decided to create a people and OD committees in common. This was an additional control to mitigate the risk of inadequate staffing compromising the delivery of high quality patient care. This committee took a medium to long-term strategic view of workforce development, recruitment and retention to supplement the more operational and shorter-term operational view presented to the Boards and Site Governance Forums on a quarterly basis.

By means of the governance mechanisms outlined above, the Trust complied with the recommendations from the “Developing Workforce Safeguards”, published by NHS Improvement in October 2018.

Compliance with CQC standards

The Trust was rated as “Requires Improvement” overall by the CQC in its latest report published in March 2020. The report showed significant and wide ranging improvement across the Trust with the overall rating for medical care reflecting particular progress in the 18 months since the previous inspection took place with the overall rating moving from ‘Inadequate’ to ‘Good’. Actions to address the any issues raised were instigated during the inspection and further improvement activity is being progressed where possible subject to the current challenges relating to the Covid-19 outbreak.

Register of Interests

The Trust has published an up-to-date register of interests for directors within the past twelve months, as required by the “Managing Conflicts of Interest in the NHS” guidance but has not been able to fully conclude this process for all decision-making staff. This process is continuing with input from the Trusts internal auditors and finance department.

For the purpose of publishing a register of interests, the scope included the executive and non-executive board members and the members of the site leadership team. The Trust maintained a register of interests for all clinical and non-clinical staff at a level confirmed by the Trusts Auditors as meeting regulatory compliance standards.

The MSE trusts recognise that the governance of conflicts of interest would benefit from a comprehensive review to align both policy and practice. Managing conflicts of interest falls within the portfolio of the Chief Commercial Officer and the Company Secretary within the merged trust so that it can be integrated within the wider corporate governance agenda. An MSE-wide conflicts of interest policy is scheduled to be approved by the Audit Committee and Trust Board early in 2020/21 for immediate implementation.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure that 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 were in place to ensure that all of the organisation's obligations under equality, diversity and human rights legislation were complied with. Further details of the trust's activities to promote equality, diversity, human rights and inclusion can be found in the Staff report.

Compliance with emergency preparedness, civil contingency and sustainability requirements

The Trust undertook risk assessments and had a sustainable development management plan in place which took account of UK Climate Projections 2018 (UKCP18). The Trust ensured that its obligations under the Climate Change Act and the Adaptation Reporting requirements were complied with. In particular:

- MEHT continued to monitor its environmental impacts as a result of providing healthcare services to its patients 24/7, 365 days a year, which included energy usage in buildings, operating medical equipment, staff journeys, procurement services, deliveries and waste management activities

- The robust capture, reporting and analysis of these activities and associated carbon dioxide emissions was contained in the Trust Board approved Sustainable Development Management Plan

- The plan was aligned to NHS policy guidelines, UK legislation such as the Climate Change Act and the Trust strategic objectives of minimising unnecessary waste and promoting the efficient management of resources. It also includes minimising man-made greenhouse gas emissions through adaptation and mitigation actions

The Trust's business continuity and emergency preparedness arrangements were tested in the latter part of the 2019/20 year as a result of the global coronavirus (COVID 19) pandemic which commenced in China in December 2019 and reached the UK and Europe in late January 2020. Our plans for a public health emergency were mobilised swiftly and effectively to manage this potentially serious respiratory tract infection, in concert with other health and care partners in Mid and South Essex, regional and national government. Measures included:

- An NHS 111 "assessment pod" was put in place at the Trust to screen suspected cases in isolation from the remainder of the hospital to minimise potential cross-infection;

- Extensive personal protective equipment (PPE) was supplied to all applicable staff across the Trust and supplies of PPE were kept under continual review at executive level;

- Immediate deep cleaning of public areas of the hospitals, such as hard surfaces and toilet facilities;

- Procurement of additional ventilators and associated clinical equipment for our intensive care facilities;

- Immediate deep cleaning of public areas of the hospitals, such as hard surfaces and toilet facilities;
- The supply of hand sanitiser was increased in clinical and non-clinical areas;
- A business continuity workshop took place to support readiness, with sub-groups focussing upon critical care and the review of clinical pathways;
- An incident management team met twice daily to monitor progress and review changing guidance from Public Health (England) and Central Government;
- Briefings for all staff on the subject of COVID 19, supplemented by written updates on the intranet.

The trust complied with national guidance in relation to social distancing and self-isolation. These measures included rolling out remote access rapidly across the Group to maximise the number of corporate staff able to work from home, closing the Hospital to visitors (with limited exceptions) and postponing all non-urgent elective outpatient and inpatient work. The MSE trusts conducted clinically urgent outpatient appointments by video-conferencing wherever possible.

Further details on the impact that the COVID-19 pandemic had upon the Trust and our partners can be found in the Overview section of the Performance Report (page 6).

Once the incident has passed, a thorough exercise will take place to ensure that all lessons learned from the management of the pandemic are captured, including the effectiveness of the business continuity and emergency preparedness plans.

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

The Board of Directors, the Audit Committees in Common and the Finance and Performance Committees in Common regularly reviewed the financial resources and financial performance of the Trust. Quarterly returns are provided on use of resources to NHS Improvement and the CQC. Weekly and monthly financial information is provided to all budget holders. Other internal processes that ensure resources are used economically, efficiently and effectively included:

Internal audit

Utilising a risk-based approach, internal audit reviewed selected systems and processes in place during the year and published reports detailing the required actions within specific areas to ensure that economy, efficiency and effectiveness of the use of resources was maintained. Progress with actions was reviewed at each meeting of the Audit Committee (latterly the Audit Committees in Common).

Financial efficiencies and cost improvement programmes

A cycle of monthly divisional performance meetings was in place throughout the year, to increase accountability of the divisions for use of resources, delivery of cost improvement plans and effective cost efficient provision. This arrangement was formalised within a Divisional Governance, Support and Accountability Framework.

The approval of individual capital expenditure projects was managed by a capital investment group and overseen by the Finance and Performance Committees in Common.

The maintenance of Clinical Effectiveness

The Governance department has overseen the implementation of guidance from the National Institute of Health and Care Excellence (NICE) and recommendations from National Confidential Enquiries and other inspecting and authoritative bodies.

The department monitored the introduction of new techniques and research and development projects ensuring patient safety, clinical and cost effectiveness of new treatments as well as the appropriate training of clinicians.

It supported clinical audits across the Trust, working to ensure that the Board received information and assurance that key clinical risks were being audited.

With the divisions and training department, evidence-based healthcare was promoted through training and education of nurses and as part of the Foundation Programme for doctors. The Trust continues to pioneer human factors training.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference

The Site Management Group was responsible for ensuring that the clinical risks and priorities of the trust were understood, assessed, mitigated and addressed. Issues and risks could be escalated by the Site Management Group to the Trust Board or its committees.

Divisional Boards and Divisional Governance Committees were responsible for ensuring that the divisions are managed efficiently and effectively and that evidence was available to support that assessment.

The Medicines Management and Safety Group oversaw the maintenance of a local drug formulary to ensure clinically appropriate and cost effective use of medicines.

Information governance

NHS Digital published new guidance for reporting IG incidents in May 2018 to bring the reporting mechanisms in line with Article 33 of the General Data Protection Regulation (GDPR), mandating the reporting of all incidents resulting in a risk to the rights and freedoms of individuals. The reporting mechanism utilises a 5x5 matrix approach, where IG incidents rated 6 or above must be reported to the ICO.

During 2019/2020 there were 3 incidents that were reported to the ICO, none of which resulted in further action from the ICO.

Date of Incident	Summary of Incident	Volume	ICO Informed	ICO Response Date	ICO Action
01/05/2019	Letter containing sensitive patient information was delivered to an incorrect address. The person that received the letter in error returned the letter to the patient. The patient stated that the letter was given back to them in an open state. The patient has stated to be suffering from increased stress due to the disclosure of the sensitive information.	1	03/05/2019	12/06/2019	No further action required.
29/08/2019	A job advert for a vacancy in the psychological therapies department was uploaded to Trac (HR job system). By mistake the member of psychology therapies staff uploaded a patient waiting list letter onto the system instead of the job description.	1	04/09/2019	22/11/2019	No further action required.
24/03/2020	A member of the staff recruitment team visited 4 overseas nurses on the way to work to reduce the number of people visiting the hospital and requested them to complete the recruitment forms. The member of staff then travelled to work by bus but then accidentally left the documents of the 4 new recruits in a bag on the bus. The documents contained name, address, date of birth, gender. The documents contained bank account details for one person, and national insurance numbers for 2 people.	4	27/03/2020	22/04/2020	No further action required.

The Board of Directors took their responsibilities towards information security and the management of risks to cyber security very seriously. The Board received cyber security training from an external expert in January 2020.

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. However during the continuance of the COVID pandemic the Trust does not anticipate having to complete a report until after 30th 2020.

Normally the content of the Quality Report and the selection of key quality priorities is a decision taken by the Board based on national and local priorities with input from a range of local stakeholders. New national guidance on timescales has been provided.

The production of the Quality Account is normally the responsibility of the Divisions of the Trust and the governance team, drawing on input from those with experience of working in the areas that affect patient safety, clinical effectiveness and patient experience. When preparing this report, the priorities agreed the previous year are likely to be reviewed. The data used within the Quality Report is extracted from the Integrated Performance Report which was scrutinised by the Quality Committee and the Board.

Additional data is gathered through the Trust's annual clinical audit programme.

Data Quality and Governance

The trust's Data Quality Policy mandated the undertaking of regular data quality audits during the year and these provided assurance on the accuracy of data within the trust. Issues with the information held on referral to treatment times came to light after the trust installed a new electronic patient record system, and with NHS England agreement the trust suspended reporting in January 2018 until the trust was confident with its data.

An action plan was developed and implemented, supported and monitored by NHSI, to validate all the data as soon as possible. Additional resources were engaged to help and a programme of training was put in place so staff were confident in how to use the patient information systems, and the trust also made sure those systems were configured to fully support Referral to Treatment. This was successful, and immediately prior to the impact of the COVID -19 pandemic the trust had agreed to and was in a position to resume reporting in May 2020 with April 2020 data.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 Trust Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in reviewing the effectiveness of the system of internal control includes the ongoing work of and reports from:

- The Board of Directors which monitors the effectiveness of the system of internal control through clear accountability arrangements;

- The Executive Team which meets formally on a weekly basis to review performance in real-time and to ensure executive oversight and approval of all service development proposals with a financial impact;

- The Audit Committee (latterly the Audit Committees in Common) which is a committee of the Board of Directors and is accountable to the Board for reviewing the establishment of an effective system of internal control and risk management. The Committee meets five times per year. The Audit Committee approves the annual audit plans and activities for internal and external audit and ensures a programme of clinical audits associated with the highest clinical risks is overseen by the Quality Committees in Common. It ensures that recommendations to improve weaknesses in the systems of control arising from audits are addressed by management. The Audit Committee reviews the Board Assurance Framework and ensures that board committees work cohesively and efficiently;

- The Quality Committees in Common and the Finance and Performance Committees in Common, which have advised me on the arrangements for clinical governance, clinical risk management, internal clinical effectiveness and patient safety, health and safety and financial performance respectively;

- The Head of Internal Audit who has provided me with an opinion that the organisation has an adequate and effective framework for risk management, governance and internal control. However, the work of Internal Audit during 2019/20, which involved trust-specific audits as well as those with a group-wide focus, identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. In particular, these related to Estates Management, Consultant Job Planning, the delivery of Cost Improvement Plans (CIP) and the methodology and implementation of Quality Improvement (QI).

Conclusion

The Trust faced challenges during 2019/20 as a sovereign statutory organisation and as a partner in the Mid and South Essex STP, particularly in relation to financial sustainability and the consistent achievement of access standards within the NHS Constitution, and managing the short and long-term impact of the COVID -19 pandemic. The new Trust's system of internal control around financial management and operational delivery will require continued vigilance and routine delivery in 2020/2021 and beyond in order to provide the Board with assurance that the system of internal control remains robust and supports the delivery of patient outcomes in a manner which is both clinically and financially sustainable.

The Board of Directors has responded to (and will continue to respond to) all the reports and correspondence from regulators. The Board has developed action plans with measurable outcomes and clear accountabilities and has strengthened the Board, corporate and clinical governance, site and executive leadership structures.

The Trust has a comprehensive improvement plan linked to the CQC inspection recommendations that has been developed and shared with the Trust's regulators.

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 to exploit the opportunities associated with service transformation across the three trusts, not least the anticipated patient benefits of the merger from April 2020.

I recognise that this is an ongoing process and believe this to be a balanced statement of the risks and controls within the Trust during 2019/20.

Clare Panniker
Chief Executive

24 June 2020

Audit Opinion and Report

Independent Auditor's Report to the Directors of Mid and South Essex NHS Foundation Trust in respect of Mid Essex Hospital Services NHS Trust

Qualified opinion on the financial statements

We have audited the financial statements of Mid Essex Hospital Services NHS Trust (the Trust) for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and 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 2019-20 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2019-20.

In our opinion, except for the possible effects of the matters described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of Mid Essex Hospital Services NHS Trust as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2019-20; and
- have been prepared in accordance with the Health and Social Care Act 2012.

Basis for qualified opinion on financial statements

In response to the effects of Covid-19 pandemic, management did not carry out the counting of physical inventories at the end of the year. As a result, we were unable to observe such procedures and were unable to obtain sufficient appropriate evidence concerning the inventory quantities held at 31 March 2020, which are included in the Statement of Financial Position at £6.92m, by using other audit procedures. Consequently, we were unable to determine whether any adjustment to this amount was necessary.

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 qualified opinion.

Emphasis of matter – basis of preparation of financial statements

As explained in Note 1.2 to the financial statements, the Trust was dissolved on 1 April 2020 having been acquired, along with Basildon and Thurrock University Hospitals NHS Foundation Trust, by Southend University Hospital NHS Foundation Trust, with the combined organisation now known as Mid and South Essex NHS Foundation Trust. The demised Trust's financial statements have, however, been prepared on a going concern basis in accordance with the requirements of the Group Accounting Manual 2019-20. Our opinion is not modified in respect of this matter.

Emphasis of matter – material valuation uncertainty related to property assets

As explained in Note 17 to the financial statements, the Royal Institute of Chartered Surveyors (RICS) has issued a valuation practice alert, whereby the valuers are required to consider material uncertainties related to the valuation of property assets where the level of valuation certainty is substantially reduced as a result of the impact of Covid-19. Based on the information received from the Trust's external valuer, Management has concluded that there are material valuation uncertainties in relation to the property assets, which should be properly considered when assessing the values reported in the Statement of Financial Position. Our opinion is not modified in respect of this matter.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- the tables of exit packages and related notes;
- the analysis of staff numbers and related notes; and
- the table of pay multiples and related narrative notes.

In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2019-20.

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 April 2020, 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 2020.

Basis for qualified conclusion on use of resources

For 2019/20, the Trust had set a deficit budget of £47.2m (which was a deficit of £65.7m before central funding of £18.3m and disallowable items of £0.2m). The outturn achieved for the year was a deficit of £46.5m (being £65.2m deficit before central funding of £18.3m and disallowable items of £0.3m), which meant the Trust met the control total for the year by £0.5m and qualified for the planned central funding. The deficit increased the negative net assets brought forward at the start of the year to £56.6m.

Internal Audit performed a detailed review of the Trust's financial governance, which was reported to the Audit Committee. This review showed an improvement in the Trust's financial governance. In addition, the Head of Internal Audit issued a positive opinion for the Trust, this including a reasonable assurance conclusion in respect of the CIPs arrangements. This shows an improvement for the Trust compared to the previous period.

The Trust had significant loans from the Department of Health and Social Care, with £196m as at 31 March 2020. After the announcement by the Department of Health and Social Care (DHSC) these will all be converted to Public Dividend Capital in the new year.
The significant cumulative deficit and the negative net asset position is evidence of weaknesses in proper arrangements regarding sustainable resource deployment.

Report to the Secretary of State

On 16 June 2020 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust has breached its statutory breakeven duty and that as a result the Trust has incurred unlawful expenditure.

Other matters

We have nothing to report in respect of the following other matters which the Local Audit and Accountability Act 2014 requires us to report to you if:

- in our opinion the Annual Governance statement does not comply with the guidance issued by NHS Improvement; or

- except as reported above, we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

Responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of Directors' reponsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

As explained in the Statement of the Chief Executive's responsibilities as the accountable officer of the Trust, the Chief Executive is responsible for ensuring that value for money is achieved from the resources available to the Trust.

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 section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

As set out in the Matters on which we report by exception section of our report there are certain other matters which we are required to report by exception.

Certificate

We certify that we have completed the audit of the accounts of Mid Esex Hospital Services NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Board of Directors of Mid and South Essex NHS Foundation Trust, as a body, in respect of Mid Essex Hopsital Services NHS Trust. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

David Eagles
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK
25 June 2020

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

Annual Accounts 2019/20

Mid Essex Hospital Services NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	323,729	298,805
Other operating income	4	35,949	18,359
Operating expenses	6, 8	(388,072)	(365,703)
Operating deficit from continuing operations		**(28,394)**	**(48,539)**
Finance income	11	156	81
Finance expenses	12	(14,637)	(13,067)
PDC dividends payable		-	-
Net finance costs		**(14,481)**	**(12,986)**
Other gains / (losses)	13	-	9
Deficit for the year from continuing operations		**(42,875)**	**(61,516)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Deficit for the year		**(42,875)**	**(61,516)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	7,093	-
Total comprehensive income / (expense) for the period		**(35,782)**	**(61,516)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	3,633	4,159
Property, plant and equipment	15	315,203	303,666
Receivables	19	2,069	1,504
Total non-current assets		**320,905**	**309,329**
Current assets			
Inventories	18	6,913	5,966
Receivables	19	29,777	16,408
Cash and cash equivalents	20	2,785	3,236
Total current assets		**39,475**	**25,610**
Current liabilities			
Trade and other payables	21	(47,368)	(35,493)
Borrowings	23	(201,460)	(40,026)
Provisions	25	(679)	(879)
Other liabilities	22	(3,068)	(2,665)
Total current liabilities		**(252,575)**	**(79,063)**
Total assets less current liabilities		**107,805**	**255,876**
Non-current liabilities			
Trade and other payables	21	(1,878)	(1,960)
Borrowings	23	(136,686)	(253,089)
Provisions	25	(4,024)	(3,348)
Other liabilities	22	(10,840)	(11,356)
Total non-current liabilities		**(153,428)**	**(269,753)**
Total assets employed		**(45,623)**	**(13,877)**
Financed by			
Public dividend capital		181,496	177,460
Revaluation reserve		54,114	47,061
Income and expenditure reserve		(281,233)	(238,398)
Total taxpayers' equity		**(45,623)**	**(13,877)**

The notes on pages 7 to 51 form part of these accounts.

The financial statements on pages 1 to 5 were approved on behalf by the Board by the audit committee on 23 June 2020 and signed on its behalf by

Chief Executive:  **Date:** 23 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**177,460**	**47,061**	**(238,398)**	**(13,877)**
Surplus/(deficit) for the year	-	-	(42,875)	**(42,875)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(40)	40	**-**
Revaluations	-	7,093	-	**7,093**
Public dividend capital received	4,036	-	-	**4,036**
Taxpayers' and others' equity at 31 March 2020	**181,496**	**54,114**	**(281,233)**	**(45,623)**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**175,961**	**47,101**	**(176,922)**	**46,140**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2018 - restated	**175,961**	**47,101**	**(176,922)**	**46,140**
Surplus/(deficit) for the year	-	-	(61,516)	**(61,516)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(40)	40	**-**
Public dividend capital received	1,499	-	-	**1,499**
Taxpayers' and others' equity at 31 March 2019	**177,460**	**47,061**	**(238,398)**	**(13,877)**

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.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(28,394)	(48,539)
Non-cash income and expense:			
Depreciation and amortisation	6.1	13,859	13,631
Net impairments	7	(3,928)	-
Income recognised in respect of capital donations	4	(91)	(155)
Amortisation of PFI deferred credit		(516)	(516)
(Increase) / decrease in receivables and other assets		(13,934)	(60)
(Increase) / decrease in inventories		(947)	521
Increase / (decrease) in payables and other liabilities		10,303	862
Increase / (decrease) in provisions		494	(318)
Net cash flows from / (used in) operating activities		**(23,154)**	**(34,574)**
Cash flows from investing activities			
Interest received		156	81
Purchase of intangible assets		-	(46)
Purchase of PPE and investment property		(11,921)	(9,502)
Sales of PPE and investment property		-	80
Receipt of cash donations to purchase assets		91	155
Net cash flows from / (used in) investing activities		**(11,674)**	**(9,232)**
Cash flows from financing activities			
Public dividend capital received		4,036	1,499
Movement on loans from DHSC		49,919	60,736
Capital element of finance lease rental payments		(548)	(747)
Capital element of PFI, LIFT and other service concession payments		(4,493)	(4,374)
Interest on loans		(3,319)	(1,599)
Other interest		(8)	(4)
Interest paid on finance lease liabilities		(71)	(35)
Interest paid on PFI, LIFT and other service concession obligations		(11,139)	(10,977)
PDC dividend (paid) / refunded		-	107
Net cash flows from / (used in) financing activities		**34,377**	**44,606**
Increase / (decrease) in cash and cash equivalents		**(451)**	**800**
Cash and cash equivalents at 1 April - brought forward		**3,236**	**2,436**
Cash and cash equivalents at 31 March	20.1	**2,785**	**3,236**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care 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 2019/20 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.

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

After taking into account all relevant factors, the Board has determined that the accounts should be prepared on a going concern basis for the year ended 31st March 2020 based on the following factors:

In March 2020, NHS Improvement (and Secretary of State for Mid Essex Hospital NHS Trust) approved the acquisition of the Trust, along with Basildon and Thurrock University Hospital NHS Foundation Trust by Southend University Hospital NHS Foundation Trust and for the combined organisation to be subsequently known as Mid and South Essex NHS Foundation Trust. Following that decision, the Board had a clear and fixed intention for the acquisition to proceed on 1 April 2020 and that there was no reason to believe that this would not be achieved.

The Trust had submitted a joint financial plan for the financial year 2020/21 and main commissioners had supported the acquisition proposal and the continuation of previously agreed contracts.

As directed by the GAM 2019/20, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. In that respect, all of the services provided previously by Mid Essex Hospital Services NHS Trust have now been taken on and are being provided by Mid and South Essex NHS Foundation Trust, and these services will continue to be delivered using the same assets as acquired from the Trust.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £196,447k are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 1.3 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).

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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.
Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.
The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.4 Other forms of income

Grants and donations
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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from 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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Property, plant and equipment

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.

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.

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

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. Until 31 March 2020 IT equipment and plant and machinery were independently valued every three years.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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.

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.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

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

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

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

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

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

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

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

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

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

On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the NHS Trust through the asset being made available to third party users. The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

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	10	71
Dwellings	24	70
Plant & machinery	3	29
Transport equipment	5	10
Information technology	5	5
Furniture & fittings	6	6

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 1.9 Intangible assets

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 where it meets the requirements set out in IAS 38.

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.

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 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.

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.

Useful lives 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**
Software licences	4	9

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.11 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 1.12 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.

Note 1.13 Financial assets and financial liabilities

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.

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 classified as subsequently measured at fair value through income and expenditure.

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at fair value through 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.

The Trust has irrevocably elected to measure the following financial assets / financial liabilities at fair value through income and expenditure: Financial Assets are recievables and include cash and cash equivalents, contract and other receivables; Financial Liabilities are borrowings and payables and inlcude borrowings and trade and other payables.

Impairment of financial assets

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).

As at the statement of Financial Position date the Trust assesses financial assets for any expected losses and allowance is established. An allowance for credit loss will be recognised only if there is objective evidence of loss as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

The Trust does not normally recognise expected credit losses in relation to other NHS Bodies.

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.

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 1.14 Leases

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

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as 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.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.15 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

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 28.2 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 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard.The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 1.24 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:

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant and are outlined in the notes as follows:-
Asset Lives - note 1.8
Provisions - note 1.15
Other expenditure - note 1.6
Partially Completed Spells - note 1.3

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

As per accounting policy 1.6.2 and note 13.1 the Trust values specialised properties on a depreciated replacement cost (DRC) basis. PPE on the balance sheet has a carrying amount of £304,182k within this £244,282k is considered to be specialised property. This includes mainly hospital buildings.

Valuations of specialised properties are undertaken by a professional RICS qualified valuer. The last valuation date was 31 March 2018.

Note 2 Operating Segments

These accounts have been prepared on the basis that there is one segment. This decision has been taken because, whilst information is provided to the Trust Board as supplementary information, major strategic decisions are taken following review of the overall position of the Trust.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	**2019/20 £000**	**2018/19 £000**
Acute services		
Elective income	53,533	52,951
Non elective income	106,607	102,929
First outpatient income	30,541	19,410
Follow up outpatient income	31,992	35,601
A & E income	16,747	14,465
High cost drugs income from commissioners (excluding pass-through costs)	25,650	26,213
Other NHS clinical income	44,942	40,902
All services		
Private patient income	1,491	1,176
Agenda for Change pay award central funding*		3,371
Additional pension contribution central funding**	8,790	
Other clinical income	3,436	1,787
Total income from activities	**323,729**	**298,805**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2019/20 £000**	**2018/19 £000**
NHS England	68,740	54,799
Clinical commissioning groups	250,122	236,961
Department of Health and Social Care	50	3,392
Other NHS providers	1,524	636
Local authorities	75	-
Non-NHS: private patients	600	407
Non-NHS: overseas patients (chargeable to patient)	891	769
Injury cost recovery scheme	844	987
Non NHS: other	883	854
Total income from activities	**323,729**	**298,805**
Of which:		
Related to continuing operations	323,729	298,805

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20	2018/19
	£000	£000
Income recognised this year	891	769
Cash payments received in-year	477	611
Amounts added to provision for impairment of receivables	498	40
Amounts written off in-year	498	77

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,434	-	**1,434**	1,367	-	**1,367**
Education and training	8,566	377	**8,943**	8,305	199	**8,504**
Non-patient care services to other bodies	2,327		**2,327**	3,169		**3,169**
Provider sustainability fund (PSF)	6,885		**6,885**	-		**-**
Financial recovery fund (FRF)	8,007		**8,007**			
Marginal rate emergency tariff funding (MRET)	3,417		**3,417**			
Receipt of capital grants and donations		91	**91**		155	**155**
Charitable and other contributions to expenditure		354	**354**		379	**379**
Amortisation of PFI deferred income / credits		516	**516**		516	**516**
Other income	3,975	-	**3,975**	4,269	-	**4,269**
Total other operating income	**34,611**	**1,338**	**35,949**	**17,110**	**1,249**	**18,359**
Of which:						
Related to continuing operations			**35,949**			**18,359**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,965	1,612

Note 6.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,308	4,006
Purchase of healthcare from non-NHS and non-DHSC bodies	4,390	4,645
Staff and executive directors costs	254,598	231,161
Remuneration of non-executive directors	106	89
Supplies and services - clinical (excluding drugs costs)	27,496	28,689
Supplies and services - general	7,058	6,094
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	32,815	33,551
Inventories written down	128	244
Consultancy costs	1,552	2,770
Establishment	1,791	1,439
Premises	15,395	14,595
Transport (including patient travel)	1,308	1,064
Depreciation on property, plant and equipment	13,333	13,124
Amortisation on intangible assets	526	507
Net impairments	(3,928)	-
Movement in credit loss allowance: contract receivables / contract assets	566	51
Movement in credit loss allowance: all other receivables and investments	(5)	131
Increase/(decrease) in other provisions	290	-
Change in provisions discount rate(s)	186	(48)
Audit fees payable to the external auditor		
audit services- statutory audit*	77	74
other auditor remuneration (external auditor only)	-	-
Internal audit costs	62	59
Clinical negligence	10,916	11,003
Legal fees	137	149
Insurance	32	31
Research and development	435	428
Education and training	2,167	1,458
Rentals under operating leases	310	376
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	5,137	4,651
Losses, ex gratia & special payments	354	196
Other services, eg external payroll	5,920	4,384
Other	612	782
Total	**388,072**	**365,703**
Of which:		
Related to continuing operations	388,072	365,703
Related to discontinued operations	-	-

* The audit figure includes non recoverable VAT (net £64.2k, 2018/19 £61.6k)

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(3,928)	-
Total net impairments charged to operating surplus / deficit	**(3,928)**	**-**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**(3,928)**	**-**

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	186,379	171,363
Social security costs	18,096	16,530
Apprenticeship levy	912	842
Employer's contributions to NHS pensions	28,993	18,740
Temporary staff (including agency)	21,667	25,329
Total gross staff costs	**256,047**	**232,804**
Recoveries in respect of seconded staff	-	-
Total staff costs	**256,047**	**232,804**
Of which		
Costs capitalised as part of assets	413	677

Note 8.1 Retirements due to ill-health

During 2019/20 there were 4 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £196k (£138k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Mid Essex Hospital Services NHS Trust is the lessee.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	310	376
Total	**310**	**376**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	286	310
- later than one year and not later than five years;	81	347
- later than five years.	50	71
Total	**417**	**728**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	156	81
Total finance income	**156**	**81**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,457	2,013
Finance leases	71	35
Interest on late payment of commercial debt	8	3
Main finance costs on PFI and LIFT schemes obligations	7,473	7,700
Contingent finance costs on PFI and LIFT scheme obligations	3,646	3,304
Total interest expense	**14,655**	**13,055**
Unwinding of discount on provisions	(18)	12
Total finance costs	**14,637**	**13,067**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	8	3

Note 13 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	9
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	**-**	**9**
Other gains / (losses)	-	-
Total other gains / (losses)	**-**	**9**

Note 14.1 Intangible assets - 2019/20

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**4,970**	**4,970**
Valuation / gross cost at 31 March 2020	**4,970**	**4,970**
Amortisation at 1 April 2019 - brought forward	**811**	**811**
Provided during the year	526	**526**
Amortisation at 31 March 2020	**1,337**	**1,337**
Net book value at 31 March 2020	**3,633**	**3,633**
Net book value at 1 April 2019	**4,159**	**4,159**

Note 14.2 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**4,924**	**4,924**
Prior period adjustments	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**4,924**	**4,924**
Additions	46	**46**
Valuation / gross cost at 31 March 2019	**4,970**	**4,970**
Amortisation at 1 April 2018 - as previously stated	**304**	**304**
Prior period adjustments	-	**-**
Amortisation at 1 April 2018 - restated	**304**	**304**
Provided during the year	507	**507**
Amortisation at 31 March 2019	**811**	**811**
Net book value at 31 March 2019	**4,159**	**4,159**
Net book value at 1 April 2018	**4,620**	**4,620**

Note 15.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**35,408**	**244,513**	**12,245**	**3,805**	**33,813**	**160**	**24,527**	**7,652**	**362,123**
Additions	-	3,332	-	5,791	3,258	-	1,468	-	**13,849**
Revaluations	-	6,554	539	-	-	-	-	-	**7,093**
Reclassifications	-	741	-	(2,022)	19	-	1,262	-	**-**
Disposals / derecognition	-	(3)	-	-	(93)	(82)	(1,115)	(5,588)	**(6,881)**
Valuation/gross cost at 31 March 2020	**35,408**	**255,137**	**12,784**	**7,574**	**36,997**	**78**	**26,142**	**2,064**	**376,184**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**8,025**	**237**	**-**	**21,579**	**160**	**20,976**	**7,480**	**58,457**
Provided during the year	-	8,192	237	-	3,247	-	1,611	46	**13,333**
Reversals of impairments	-	(3,928)	-	-	-	-	-	-	**(3,928)**
Reclassifications	-	(142)	-	-	142	-	-	-	**-**
Disposals / derecognition	-	(3)	-	-	(93)	(82)	(1,115)	(5,588)	**(6,881)**
Accumulated depreciation at 31 March 2020	**-**	**12,144**	**474**	**-**	**24,875**	**78**	**21,472**	**1,938**	**60,981**
Net book value at 31 March 2020	**35,408**	**242,993**	**12,310**	**7,574**	**12,122**	**-**	**4,670**	**126**	**315,203**
Net book value at 1 April 2019	**35,408**	**236,488**	**12,008**	**3,805**	**12,234**	**-**	**3,551**	**172**	**303,666**

Note 15.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**35,408**	**241,325**	**12,245**	**1,995**	**31,266**	**160**	**23,571**	**7,584**	**353,554**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**35,408**	**241,325**	**12,245**	**1,995**	**31,266**	**160**	**23,571**	**7,584**	**353,554**
Additions	-	2,672	-	2,326	3,509	-	956	68	**9,531**
Reclassifications	-	516	-	(516)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(962)	-	-	-	**(962)**
Valuation/gross cost at 31 March 2019	**35,408**	**244,513**	**12,245**	**3,805**	**33,813**	**160**	**24,527**	**7,652**	**362,123**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**-**	**-**	**-**	**19,148**	**156**	**19,485**	**7,435**	**46,224**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2018 - restated	**-**	**-**	**-**	**-**	**19,148**	**156**	**19,485**	**7,435**	**46,224**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	8,025	237	-	3,322	4	1,491	45	**13,124**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(891)	-	-	-	**(891)**
Accumulated depreciation at 31 March 2019	**-**	**8,025**	**237**	**-**	**21,579**	**160**	**20,976**	**7,480**	**58,457**
Net book value at 31 March 2019	**35,408**	**236,488**	**12,008**	**3,805**	**12,234**	**-**	**3,551**	**172**	**303,666**
Net book value at 1 April 2018	**35,408**	**241,325**	**12,245**	**1,995**	**12,118**	**4**	**4,086**	**149**	**307,330**

Note 15.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	35,408	102,777	1,937	7,574	9,907	-	4,669	105	**162,377**
Finance leased	-	-	-	-	785	-	-	-	**785**
On-SoFP PFI contracts and other service concession arrangements	-	139,747	10,373	-	-	-	-	-	**150,120**
Owned - donated	-	469	-	-	1,430	-	1	21	**1,921**
NBV total at 31 March 2020	**35,408**	**242,993**	**12,310**	**7,574**	**12,122**	**-**	**4,670**	**126**	**315,203**

Note 15.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	35,408	95,712	1,426	3,805	9,356	-	3,549	130	**149,386**
Finance leased	-	-	-	-	1,231	-	-	-	**1,231**
On-SoFP PFI contracts and other service concession arrangements	-	140,286	10,582	-	-	-	-	-	**150,868**
Owned - donated	-	490	-	-	1,647	-	2	42	**2,181**
NBV total at 31 March 2019	**35,408**	**236,488**	**12,008**	**3,805**	**12,234**	**-**	**3,551**	**172**	**303,666**

Note 16 Donations of property, plant and equipment

During the year donations made by Mid Essex Hospital Services Charitable Fund were utilised to purchase a number of items of medical equipment and make improvements to clinical areas.

Note 17 Revaluations of property, plant and equipment

There was a valuation on 31 March 2018 of land, buildings and dwellings. This was carried out by Stephen Boshier of Boshier & Company Chartered Surveyors, a RICS approved surveyor.

The valuations were in accordance with the requirements of the RICS Valuation Standards sixth edition and the International Valuation Standards. The valuation of each property was on the basis of market value, subject to the following assumptions:

i) For owner occupied property: that the property would be sold as part of the continuing enterprise in occupation.
The Valuer's opinion of Market Value was primarily derived using:
ii) comparable recent market transactions on arm's length terms;
iii) the depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transaction of this type of asset except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

In making these judgements, the Trust is aware that the RICS has issued a valuation practice notice which gives guidance to valuers where a valuer declares a materiality uncertainty attached to a valuation in light of the impact of COVID-19 on markets. The Trust has not obtained a valuation for 2019/20 but it should be noted that there may now be a greater uncertainty in markets on which the desktop valuation obtained in 2017/18 and reflected in these financial statements is based.

Note 18 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	2,318	2,134
Consumables	4,566	3,794
Energy	29	38
Total inventories	**6,913**	**5,966**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £59,365k (2018/19: £60,379k). Write-down of inventories recognised as expenses for the year were £128k (2018/19: £244k).

Note 19.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	28,049	13,991
Allowance for impaired contract receivables / assets	(1,833)	(1,636)
Allowance for other impaired receivables	(204)	(260)
Prepayments (non-PFI)	2,635	2,156
VAT receivable	700	1,129
Other receivables	430	1,028
Total current receivables	**29,777**	**16,408**
Non-current		
Contract receivables	31	43
Contract assets	999	1,065
Prepayments (non-PFI)	341	341
Other receivables	698	55
Total non-current receivables	**2,069**	**1,504**
Of which receivable from NHS and DHSC group bodies:		
Current	20,346	8,843
Non-current	657	-

Note 19.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,636**	**260**	**-**	**1,881**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**1,636**	**260**	**-**	**1,881**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			1,722	(1,722)
New allowances arising	581	14	168	131
Reversals of allowances	(15)	(19)	(117)	-
Utilisation of allowances (write offs)	(369)	(51)	(137)	(30)
Allowances as at 31 Mar 2020	**1,833**	**204**	**1,636**	**260**

Note 20.1 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.

	2019/20	2018/19
	£000	£000
At 1 April	**3,236**	**2,436**
Prior period adjustments	-	-
At 1 April (restated)	**3,236**	**2,436**
Net change in year	(451)	800
At 31 March	**2,785**	**3,236**
Broken down into:		
Cash at commercial banks and in hand	13	13
Cash with the Government Banking Service	2,772	3,223
Total cash and cash equivalents as in SoFP	**2,785**	**3,236**
Total cash and cash equivalents as in SoCF	**2,785**	**3,236**

Note 20.2 Third party assets held by the trust

Mid Essex Hospital Services NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Monies on deposit	2	2
Total third party assets	**2**	**2**

Note 21.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	22,948	16,754
Capital payables	3,767	1,856
Accruals	10,884	7,870
Receipts in advance and payments on account	82	82
Social security costs	2,853	2,544
Other taxes payable	2,498	2,289
Other payables	4,336	4,098
Total current trade and other payables	**47,368**	**35,493**
Non-current		
Receipts in advance and payments on account	1,878	1,960
Total non-current trade and other payables	**1,878**	**1,960**
Of which payables from NHS and DHSC group bodies:		
Current	13,808	7,825
Non-current	-	-

Note 22 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	2,552	2,149
Deferred PFI credits / income	516	516
Total other current liabilities	**3,068**	**2,665**
Non-current		
Deferred PFI credits / income	10,840	11,356
Total other non-current liabilities	**10,840**	**11,356**

Note 23.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	196,447	35,155
Obligations under finance leases	270	389
Obligations under PFI, LIFT or other service concession contracts	4,743	4,482
Total current borrowings	**201,460**	**40,026**
Non-current		
Loans from DHSC	-	111,236
Obligations under finance leases	117	530
Obligations under PFI, LIFT or other service concession contracts	136,569	141,323
Total non-current borrowings	**136,686**	**253,089**

Refer to Note 32 regarding the re-classification of loans from DHSC from non-current to current borrowings at 31 March 2020.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**146,391**	**919**	**145,805**	**293,115**
Cash movements:				
Financing cash flows - payments and receipts of principal	49,919	(548)	(4,493)	**44,878**
Financing cash flows - payments of interest	(3,319)	(71)	(7,473)	**(10,863)**
Non-cash movements:				
Additions	-	16	-	**16**
Application of effective interest rate	3,456	71	7,473	**11,000**
Carrying value at 31 March 2020	**196,447**	**387**	**141,312**	**338,146**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**84,987**	**840**	**150,179**	**236,006**
Prior period adjustment	**-**	**-**	**-**	**-**
Carrying value at 1 April 2018 - restated	**84,987**	**840**	**150,179**	**236,006**
Cash movements:				
Financing cash flows - payments and receipts of principal	60,736	(747)	(4,374)	**55,615**
Financing cash flows - payments of interest	(1,599)	(35)	(7,700)	**(9,334)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	254	-	-	**254**
Additions	-	826	-	**826**
Application of effective interest rate	2,013	35	7,700	**9,748**
Carrying value at 31 March 2019	**146,391**	**919**	**145,805**	**293,115**

Note 24 Finance leases

Note 24.1 Mid Essex Hospital Services NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**449**	**1,049**
of which liabilities are due:		
- not later than one year;	322	459
- later than one year and not later than five years;	127	590
- later than five years.	-	-
Finance charges allocated to future periods	(62)	(130)
Net lease liabilities	**387**	**919**
of which payable:		
- not later than one year;	270	389
- later than one year and not later than five years;	117	530
- later than five years.	-	-

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2019	**3,046**	**609**	**43**	**529**	**4,227**
Change in the discount rate	**142**	**44**	**-**	**-**	**186**
Arising during the year	**146**	**15**	**90**	**837**	**1,088**
Utilised during the year	(275)	(37)	(3)	(430)	**(745)**
Reversed unused	**(4)**	**-**	**(5)**	**(26)**	**(35)**
Unwinding of discount	**(15)**	**(3)**	**-**	**-**	**(18)**
At 31 March 2020	**3,040**	**628**	**125**	**910**	**4,703**
Expected timing of cash flows:					
- not later than one year;	270	31	125	**253**	**679**
- later than one year and not later than five years;	1,083	151	-	**67**	**1,301**
- later than five years.	1,687	446	-	**590**	**2,723**
Total	**3,040**	**628**	**125**	**910**	**4,703**

Early Departure costs are calculated in accordance with NHS Pensions Scheme rules based on age, salaries and length of service of employees effected.

Legal Claims relate to on going insurance claims against the Trust's employee liability insurance and public liability insurance.

Other provisions are injury benefits due to staff who have left the employment of the Trust, provisions in relation to the allowance payable to the government for CO2 emissions, clinicians pension tax scheme and employment tribunal claims subject to final hearings.

Note 25.2 Clinical negligence liabilities

At 31 March 2020, £276,466k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Mid Essex Hospital Services NHS Trust (31 March 2019: £201,242k).

Note 26 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(86)	(43)
Gross value of contingent liabilities	**(86)**	**(43)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(86)**	**(43)**
Net value of contingent assets	**-**	**-**

Contingent liabilities relate to public / employee claims as notified by NHS Resolution, (19 cases in 2019/20) and (10 cases in 2018/19).

The liabilities are based on the excess value of the claim against the likelihood of success.

The Trust has a S106 agreement with Essex County Council relating to infrastructure works to be carried out in order to conclude planning obligations.

Note 27 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	260	414
Total	**260**	**414**

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

Staff Accommodation Scheme

During 2005/06, the Trust concluded contracts under the Private Finance Initiative (PFI) with Swan Housing Association Limited for the construction and provision of staff residential accommodation including the management of the accommodation and other related services, i.e. cleaning, estates, etc.

The PFI scheme was approved by the NHS Executive and HM Treasury. Following an assessment of the scheme, in the light of HM Treasury's "Technical Note 1 (revised) How to account for PFI transactions", in the Trust's opinion the scheme was accounted for off of the Statement of Financial Position. Given the change to IFRS this has now been reconsidered under IFRIC 12 and in the Trust's opinion the scheme should now be accounted for on the Statement of Financial Position.

Under the contract Trust staff have the first option on the accommodation. However, where they do not require the property there is a priority list of alternative public sector workers to whom the accommodation may be offered.

The accommodation was valued on 31 March 2018 at £10.8 million. The only payment that the Trust makes under the scheme is for those on-call rooms and medical student rooms that the Trust wishes to rent. All rental income is paid directly to the operator, Swan Housing Association.

New staff accommodation has been constructed by Swan Housing Association Limited on the Broomfield Hospital Site. This accommodation will transfer to the Trust at nil cost at the end of the 35 year initial concession period, which commenced in 2007/08 when the property construction was completed.

In the event of Operator default, the Trust has the option to re-tender the contract or pay a termination sum determined by an expert valuer.

Hospital facilities scheme

During 2007/08, the Trust concluded contracts under the Private Finance Initiative (PFI) with By Chelmer PLC for the construction and provision of hospital accommodation including the provision of related services, i.e. estates maintenance, etc.

The PFI scheme was approved by East of England Strategic Health Authority, the Department of Health and HM Treasury. Following an assessment of the scheme, in the light of HM Treasury's "Technical Note 1 (revised) How to account for PFI transactions", in the Trust's opinion the scheme was to be accounted for off balance sheet. However, HM Treasury determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognised the PFI asset as an item of property, plant and equipment together with a liability to pay for it when it was handed over in August 2010. The services received under the contract are recorded as operating expenses.

The substance of the contract, which will run for 33 years, is that the Trust has a finance lease. The Trust makes monthly repayments to reduce the liability and for services received.

Braintree Community Hospital

Following the re-organisation of NHS organisations, the PFI scheme operated by Mid Essex Primary Care Trust was transferred to the Trust under modified absorption accounting. The PFI contract is with GH Braintree Limited. For the same reasons as the existing PFI scheme this was considered to be shown on balance sheet. The Trust therefore recognised an asset as an item of property, plant and equipment together with a liability. The services received under the contract are recorded as an operating expense.

The substance of the contract, which will run until 2040, is that the Trust has a finance lease. The Trust makes monthly repayments to reduce the liability and for services received.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**241,649**	**253,614**
Of which liabilities are due		
- not later than one year;	11,980	11,954
- later than one year and not later than five years;	45,319	46,390
- later than five years.	184,349	195,270
Finance charges allocated to future periods	(100,337)	(107,809)
Net PFI, LIFT or other service concession arrangement obligation	**141,312**	**145,805**
- not later than one year;	4,743	4,482
- later than one year and not later than five years;	18,801	18,895
- later than five years.	117,768	122,428

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**662,901**	**689,657**
Of which payments are due:		
- not later than one year;	22,052	21,866
- later than one year and not later than five years;	93,928	92,610
- later than five years.	546,920	575,181

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**21,419**	**20,601**
Consisting of:		
- Interest charge	7,473	7,700
- Repayment of balance sheet obligation	4,493	4,375
- Service element and other charges to operating expenditure	5,137	4,651
- Capital lifecycle maintenance	670	571
- Contingent rent	3,646	3,304
Total amount paid to service concession operator	**21,419**	**20,601**

Note 29 Financial instruments

Note 29.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

As per note 26.3, the Trust has recognised financial liabilities in respect of PFI's of £141.3m (2018/19, £145.8m). Whilst these liabilities are recognised in the financial statements at amortised cost, the repayments to the PFI operators are indexed by RPI and so the Trust is exposed to price risk in respect of the fair value of future cash flows. As noted in accounting policy 1.6.4, the RPI element of the cash flow is accounted for as a contingent rental as and when it falls due.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in note 19.1, trade and other receivables.

Liquidity risk

The Trust's operating costs are incurred under contracts with other public sector bodies, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	27,407	-	-	**27,407**
Cash and cash equivalents	2,785	-	-	**2,785**
Total at 31 March 2020	**30,192**	**-**	**-**	**30,192**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	14,286	-	-	**14,286**
Cash and cash equivalents	3,236	-	-	**3,236**
Total at 31 March 2019	**17,522**	**-**	**-**	**17,522**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	196,447	-	**196,447**
Obligations under finance leases	387	-	**387**
Obligations under PFI, LIFT and other service concession contracts	141,312	-	**141,312**
Trade and other payables excluding non financial liabilities	41,935	-	**41,935**
Total at 31 March 2020	**380,081**	**-**	**380,081**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	146,391	-	**146,391**
Obligations under finance leases	919	-	**919**
Obligations under PFI, LIFT and other service concession contracts	145,805	-	**145,805**
Trade and other payables excluding non financial liabilities	30,578	-	**30,578**
Total at 31 March 2019	**323,693**	**-**	**323,693**

Note 29.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	243,395	70,604
In more than one year but not more than two years	9,438	60,122
In more than two years but not more than five years	9,480	70,539
In more than five years	117,768	122,428
Total	**380,081**	**323,693**

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	1	-
Bad debts and claims abandoned	227	616	227	177
Stores losses and damage to property	1	191	-	-
Total losses	**229**	**807**	**228**	**177**
Special payments				
Compensation under court order or legally binding arbitration award	2	12	-	-
Ex-gratia payments	34	26	48	87
Total special payments	**36**	**38**	**48**	**87**
Total losses and special payments	**265**	**845**	**276**	**264**
Compensation payments received		-		-

Note 31 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any transactions with Mid Essex Hospital Services NHS Trust.

The Department of Health is regarded as a related party. During the year, and during the prior year, Mid Essex Hospital Services NHS Trust has had a significant number of transactions with entities for which the Department is regarded as the parent Department. Significant transactions have been with:

During 2019/20:

Barking And Dagenham CCG

Basildon And Brentwood CCG

Castle Point And Rochford CCG

Cambridge & Peterborough CCG

East And North Hertfordshire CCG

Enfield CCG

Havering CCG

Ipswich And East Suffolk CCG

Mid Essex CCG

Newham CCG

North East Essex CCG

Redbridge CCG

Southend CCG

Thurrock CCG

Waltham Forest CCG

West Essex CCG

West Suffolk CCG

NHS England - East of England Regional Office

NHS England - East Midlands Specialised Commissioning Hub

NHS England - East of England Specialised Commissioning Hub

Barts Health NHS Trust

Department of Health & Social Care

Health Education England

NHS Digital

Basildon & Thurrock University Hospitals NHS Foundation Trust

East Suffolk & North Essex NHS Foundation Trust

Essex Partnership University NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Southend University Hospitals NHS Foundation Trust

The Princess Alexandra NHS Trust

NHS Resolution

NHS Blood and Transplant

During 2018/19:

Barking And Dagenham CCG
Basildon And Brentwood CCG
Castle Point And Rochford CCG
Cambridge & Peterborough CCG
East And North Hertfordshire CCG
Havering CCG
Ipswich And East Suffolk CCG
Mid Essex CCG
Newham CCG
North East Essex CCG
Redbridge CCG
Southend CCG
Thurrock CCG
Waltham Forest CCG
West Essex CCG
West Suffolk CCG
NHS England - East Local Office
NHS England - East Midlands Specialised Commissioning Hub
NHS England - East of England Specialised Commissioning Hub
Barts Health NHS Trust
Department of Health & Social Care
Health Education England
NHS Digital
Basildon & Thurrock University Hospitals NHS Foundation Trust
East Suffolk & North Essex NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Southend University Hospitals NHS Foundation Trust
The Princess Alexandra NHS Trust
NHS Resolution
NHS Blood and Transplant

In addition, the Trust has had a number of transactions with other government departments and other central and local government bodies during 2019/20 and 2018/19. Significant transactions have been with:

HM Revenue & Customs
Plasma Resources UK (including Bio Products Laboratory)

NHS Pension Scheme (Own staff employers and employees contributions)
National Insurance Fund
Essex County Council

The Trust has also received revenue and capital payments from Mid Essex Hospital Charitable Fund, see note 4, for which the Trust is the corporate Trustee. The audited accounts of the Charitable Fund are included in a separate annual report. An administration fee is charged to the Charitable Fund £79k 2019/20 (£79k 2018/19).

Due to the national Covd-19 emergency, a number of our employees have enabled contacts, or brokered discussions for the Trust with potential PPE suppliers. Where these discussions have led to a transaction, there have been no occasions where our employees have had an interest in the supplying entity. However, for transparency, we have sought declarations of interest where their involvement has been more extensive in facilitating a purchase.

Note 32 Events after the reporting date

The financial statements were authorised for issue by the Trust Board on XX May 2020. Where events take place before this date providing information about conditions existing at 31 March 2020, the figures in the Financial Statements and notes have been adjusted in all material respects to reflect the impact of this information.

On 1 April 2020, the Trust merged with Basildon & Thurrock University Hospitals NHS Foundation Trust and Southend University Hospitals NHS Foundation Trust and became Mid and South Essex NHS Foundation Trust.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £196,447k as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 33 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	91,541	213,505	90,530	211,147
Total non-NHS trade invoices paid within target	74,245	189,082	56,020	168,919
Percentage of non-NHS trade invoices paid within target	81.1%	88.6%	61.9%	80.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,776	30,560	2,612	22,305
Total NHS trade invoices paid within target	2,049	23,054	1,434	13,239
Percentage of NHS trade invoices paid within target	73.8%	75.4%	54.9%	59.4%

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

Note 34 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2019/20 £000	2018/19 £000
Cash flow financing	49,365	56,314
External financing requirement	**49,365**	**56,314**
External financing limit (EFL)	49,738	58,305
Under / (over) spend against EFL	**373**	**1,991**

Note 35 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	13,849	9,577
Less: Disposals	-	(71)
Less: Donated and granted capital additions	(91)	(155)
Charge against Capital Resource Limit	**13,758**	**9,351**
Capital Resource Limit	14,193	10,986
Under / (over) spend against CRL	**435**	**1,635**

Note 36 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(46,544)
IFRIC 12 breakeven adjustment	1,490
Breakeven duty financial performance surplus / (deficit)	**(45,054)**

Note 37 Breakeven duty rolling assessment

The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a meteriality threshold of 0.5% of operating income) it should be recovered within the subsequent two financial years.

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,551	3,660	(2,156)	1,100	(19,348)
Breakeven duty cumulative position	125	2,676	6,336	4,180	5,280	(14,068)
Operating income		238,050	256,086	262,953	275,179	261,638
Cumulative breakeven position as a percentage of operating income		1.1%	2.5%	1.6%	1.9%	(5.4%)

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(33,352)	(39,887)	(24,306)	(50,915)	(59,752)	(45,054)
Breakeven duty cumulative position	(47,420)	(87,307)	(111,613)	(162,528)	(222,280)	(267,334)
Operating income	281,103	288,727	315,504	308,405	317,164	359,678
Cumulative breakeven position as a percentage of operating income	(16.9%)	(30.2%)	(35.4%)	(52.7%)	(70.1%)	(74.3%)

NHS Improvement have given guidance that the first year for consideration for the breakeven duty should be 2009/10. The Trust is subject to a three year period for recovery of any deficit incurred.