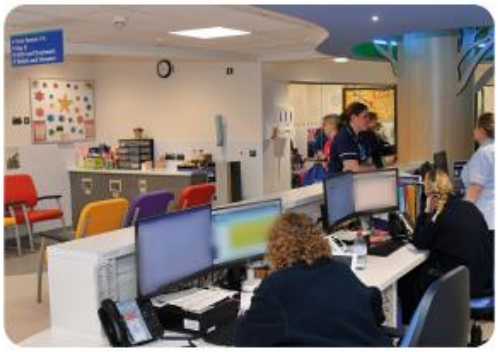
East Suffolk and
North Essex
NHS Foundation Trust



East Suffolk and
North Essex NHS
Foundation Trust

Annual Report and Accounts 2024/25

East Suffolk and North Essex NHS Foundation Trust

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

Contents

Useful contact information

If you would like to make any comments about this annual report, please contact:

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Patient advice and liaison service (PALS)

Our PALS service is a non-clinical point of contact within the hospital for patients, relatives, carers and friends requiring advice or assistance in relation to services provided by ESNEFT. The PALS service is independent and confidential, and we will not speak to anyone about the patient unless appropriate permission has been obtained.

If you have spoken to the ward or clinical staff and still require additional support, PALS is there to help resolve queries as quickly and easily as possible. The PALS staff will co-ordinate your concerns to the most appropriate department, and it is the responsibility of the departmental senior management team to respond directly to you and ensure your questions or concerns are fully addressed. We offer advice for you and your family and will listen to your concerns, feedback and queries, helping to resolve these quickly on your behalf.

You can contact PALS at Colchester Hospital via freephone 0800 7837328, Ipswich Hospital freephone 0800 3287624, or by emailing pals@esneft.nhs.uk. Please state whether your email is about Ipswich or Colchester Hospital, or one of our community sites. More information is available on our website.

We care, do you?

Becoming a member of our foundation trust gives you the opportunity to get involved in decisions that affect the services that we provide to you and your family. Membership is open to anyone over the age of 16 who lives in our area. To find out more, email ft.membership@esneft.nhs.uk, or visit www.esneft.nhs.uk and click on “get involved”.

General information and inquiries

Email: communications@esneft.nhs.uk
Full contact details and more contact information is available at www.esneft.nhs.uk

You can read ESNEFT’s Quality Account for 2024/25 at www.esneft.nhs.uk

For a copy of this annual report in Braille, large print or foreign language formats, please call 01473 704781

The Chair's welcome

This has been an exceptional year for our Trust thanks to the commitment, professionalism and energy of all our staff and volunteers, and the continuing generosity of the communities we serve.

Our £350 million investment programme throughout ESNEFT continued to deliver innovative care in state-of-the-art new buildings.

A new Urgent and Emergency Care Centre at Ipswich Hospital successfully opened for patients in September 2024. Patient care has been transformed with the new Accident & Emergency (A&E) department and Urgent Treatment Centre (UTC). The new, dedicated UTC offers treatment for urgent but not life-threatening conditions, freeing up the A&E to focus on providing care for the most critically ill and seriously injured patients. There is a single front door for all walk-in urgent and emergency patients, making sure they are seen and treated by the right team.

A new CT scanner opened in the centre, funded by Colchester & Ipswich Hospitals Charity. A dedicated theatre suite also opened on the first floor of the building in July.

A new Children's Centre at Ipswich Hospital was celebrated with a tea party for former and current patients, parents and staff. The multi-million-pound project has seen the whole unit refurbished and extended. A new ward and extra clinic spaces have been created, along with a school room, children's assessment unit, outdoor play area and themed receptions and waiting areas. New treatment rooms, a high dependency bay and a calming sanctuary room for patients with mental health difficulties have also been added.

The project was paid for by the Trust and with funds raised through Colchester & Ipswich Hospitals Charity Children's Appeal. It is a fantastic project which has transformed a dated, cramped area into a bright and welcoming space which will enhance the experience that young patients, their families and carers have when they come to hospital. This high quality, modern environment matches the high standard of care the teams provide. My thanks to everyone involved and especially to consultant paediatrician Lauren Filby who has championed the project from the very start.

Our trail-blazing new centre - the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) in the Dame Clare Marx Building at Colchester Hospital successfully opened in November 2024. Helping us to change the lives of up to 10,000 people each year, this is one of the largest centres of its kind in Europe and has created 300 jobs in the area. With eight theatres, three wards and 72 inpatient beds, the state-of-the-art centre is dedicated to elective surgery for bones, joints and muscles.

For our patients, it means operations are less likely to be postponed and they won't have to wait as long for surgery so that they can get back to living their lives, pain free as soon as possible.

The centre honours Dame Clare Marx, who was an orthopaedic surgeon at Ipswich Hospital and the first female president of both the British Orthopaedic Association and the Royal College of Surgeons of England.

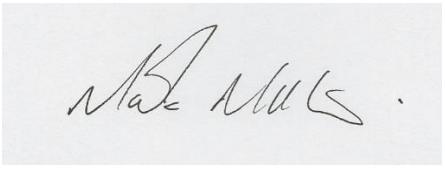
A major development programme at Clacton Hospital has created a new centre for the maternity service. All antenatal and postnatal care will now be delivered from the modern unit, which is on the ground floor and easy to access. This work will include building a new birthing suite on the first floor of the hospital, which will provide a safe, modern environment for families. The new birthing unit is expected to open in May 2025.

Our community services make sure that we have an integrated response supporting patients back into the community, especially now we are using virtual wards to make sure our patients can return home and maintain their independence while still being carefully monitored.

Up to 1,000 clinical colleagues work within the community setting, supporting around 30,000 people each month, focusing on prevention, education and self-management and working collaboratively with agencies such as social care, primary care, hospices and the voluntary sector. A community services showcase week helped colleagues and system partners learn more about how patients can be supported to stay well for longer in their homes and avoid unnecessary hospital admission.

It is always our people – staff and volunteers – who make these investments in facilities and innovation a reality and make life better for the communities we serve. We have wide-reaching staff recognition programmes in place including our staff awards which were held in November 2024, long service awards, ESNEFT commendations, and a Greate scheme. That feeling of being recognised and rewarded is key to the NHS People Promise and we are committed to valuing and thanking our colleagues.

My thanks to all our staff colleagues, volunteers, supporters and system partners for their hard work. I would also like to thank Helen Taylor, Chair of ESNEFT until 31 March 2025 which was the end of her six-year term of office, for her immense contribution to the Trust.



Mark Millar
Interim Chair

Performance Report

The performance report helps readers to understand and assess how the Trust has performed during 2024/25 in meeting its main objectives and to assess how risks are being managed.

The report has been prepared in accordance with the relevant sections of the Companies Act 2006, as interpreted in the HM Treasury's Financial Reporting Manual and the NHS foundation trust annual reporting manual, as required by Schedule 7 of the NHS Act 2006. We have also taken account of NHS England and the Financial Reporting Council guidance on the strategic report (November 2015) to ensure that the report is fair, balanced, understandable, comprehensive but concise and forward-looking.

The final data setting out the numbers of patients we have treated and performance against a range of indicators can be found later in this report.

Our focus remains on our patients at the heart of everything we do, and we know that some have been waiting far longer for treatment than we would like.

At the end of March, our performance can be summarised as set out below:

Urgent and emergency care

- Planned admissions and diagnostics - a focus on change has enabled 78.4% performance to be achieved against the A&E 4-hour standard, continued improvements for ambulance handovers across both the Colchester and Ipswich sites and a reduction in 12 hour waits during March 2025.
- The momentum of the UTC model of care at Ipswich, the huge improvements at Colchester through the "Be the Change" initiative and the "home for lunch" initiative is supporting quicker treatment for our patients.
- Support has been provided, particularly at Colchester Hospital, to those patients who have been cared for in corridors and temporary bed spaces. This has been necessary as the safest option for managing the risk across the health and care system due to high occupancy levels, enabling ambulances to respond to emergency calls. There have been delays in patients moving to the right specialty for their ongoing care needs although good engagement has been seen with other organisations, with our staff, and a multi-professional forum is in place to seek to mitigate any risks. From a fundamentals of care perspective, we keep patients safe with rapid assessment and early decisions through the Community at the Front Door service and supporting the sickest patients. Consistent processes are in place at both acute sites. Corridor care is not regarded as acceptable, and the focus is on enabling a return to what we believe is the right care provision in the emergency department (ED).

Cancer services

- There has been monthly improvement across all cancer standards. The aim is to do today's work today as we recognise the impact on patients if they have to wait for their treatment.

Referral to treatment waiting times for elective care

- Diagnostic performance has improved with 94.7% achieved, the first time for over 18 months.
- No patients have waited over 65 weeks for treatment for capacity reasons.
- The number of patients waiting over 52 weeks continues to reduce. At the end of March, of 84,598 patients waiting to be treated in April 2024, only 2,504 did not have a date for their treatment.

In addition to delivery of operational performance standards, the financial position was achieved with a financial surplus of £3.5m reported.

The Trust continues to deliver training and support for management colleagues. More than three quarters of our managers have completed one of the three tiered Leadership programmes - over 1,600 staff. A further 18% are currently on the programmes.

Chief Executive's overview

Our ambition to deliver the highest quality care for all the communities we serve remains as strong as when we first became ESNEFT. The recent changes to how the NHS is managed and the expectations of all NHS organisations to become more efficient and to increase our productivity we view as opportunities to further improve our performance.

This year we have continued to see our £350 million investment programme deliver shorter waiting times for patients. I continue to be extremely grateful for the dedication of all of our nearly 13,000 colleagues working across our sites and in the community who provide care for thousands of patients every day.

Providing this highest quality care for all our community is the motivation that drives every single member of the team and is at the heart of all the decisions we make.

In December 2024, the Trust Board made the decision to contract all soft facilities management services - catering, housekeeping, cleaning, portering and security - to an external partner, moving to a single, consistent approach across all our sites. Sodexo was confirmed as our new partner, and we are working closely together to make sure there is a smooth transition.

This was a difficult decision and was possible through the many months of work to fully assess the options for the best provision for our patients in the future. The work to deliver that decision was managed by a transitional board, which included two non-executive directors, leading to the successful transfer of services at Colchester Hospital in-year, and Ipswich Hospital and community services early in 2025/26.

During the period leading up to the decision, and once the decision was made, the Board worked with trades unions and our staff to provide them with the information they needed and to answer any questions colleagues had. This included engagement sessions for impacted staff.

We've had continued success with robotic surgery at the Trust and it's becoming business as usual for many specialities such as colorectal procedures. At Christmas we reached our milestone for treated 2,000 patients using our Da Vinci robots and the number continues to grow.

AI – artificial intelligence – is becoming part of our everyday inside and outside healthcare and we're utilising AI tools across the Trust, whether it's for detecting fractures in broken bones or to highlight abnormalities on x-rays.

I am proud of the strong research presence we have at the Trust, and this has continued to be a big part of the service we provide by offering patients the opportunity to join studies they may be eligible for, and to help shape the care we provide patients in the future.

Behind the scenes there has been an enormous amount of work being done for our new electronic patient record system called EpicEPR. We're going live with the system in October this year, which will completely transform how we work. Patients will see huge benefits from this, by using the connected app or website MyChart.

This isn't an IT project but a whole new way of working by joining up departments through one single system for patient notes. This is incredibly exciting as it will change how we work, and the care patients receive for the better. Change can be difficult but is essential for the Trust and the NHS. We know embracing technologies and adapting our approach is crucial to provide safe and effective care for our patients. EpicEPR uses one of the best systems on the market as we know the importance of investing in this now for the years to come.

I'm also pleased to report on the development and growth of the opportunities available to all our colleagues. We have a strong and established apprenticeship programme across the whole Trust for all levels. Our emerging leader training has seen many members of staff benefit from personal development.

Our first medical doctor degree apprenticeship programme, in partnership with Anglia Ruskin University, has had a fantastic first year offering 25 places to individuals who would not have previously been able to train to become a doctor. Our second cohort of 25 begins in September.

We continue to prioritise support for the health and wellbeing of staff as we know working in the NHS can at times be tough. Our excellent wellbeing services offer psychological therapy, counselling, mental health first aid, help for sleep, anxiety, mindfulness and stress, plus an employee assistant programme which includes emotional support, help with financial management, legal advice, family matters and more.

Our staff networks are helping colleagues who have historically been marginalised in the workplace and play an integral role in our promise to create a more equal, diverse and inclusive ESNEFT. You can read more about our equality, diversity and inclusion commitments and our staff networks in the Staff Report section of this annual report.

Our commitment to being an anchor organisation with our system partners is unwavering. This includes widening access to quality work, purchasing for social benefit, using buildings and spaces to support communities, reducing our environmental impact and working closely with communities and local partners.

This year has been one of significant improvement in bringing shorter waiting times for our patients especially in trauma and orthopaedics with the opening of our new Essex and Suffolk Elective Orthopaedic Centre in the Dame Clare Marx Building at Colchester Hospital. We are committed to bringing waiting times down further.

As we navigate the challenging and changing waters ahead with the NHS as a whole, I want to say thank you to all our colleagues at ESNEFT and to our partner organisations who play a vital role in supporting us and the services we provide.

Your support is hugely appreciated.

Nick Hulme
Chief Executive

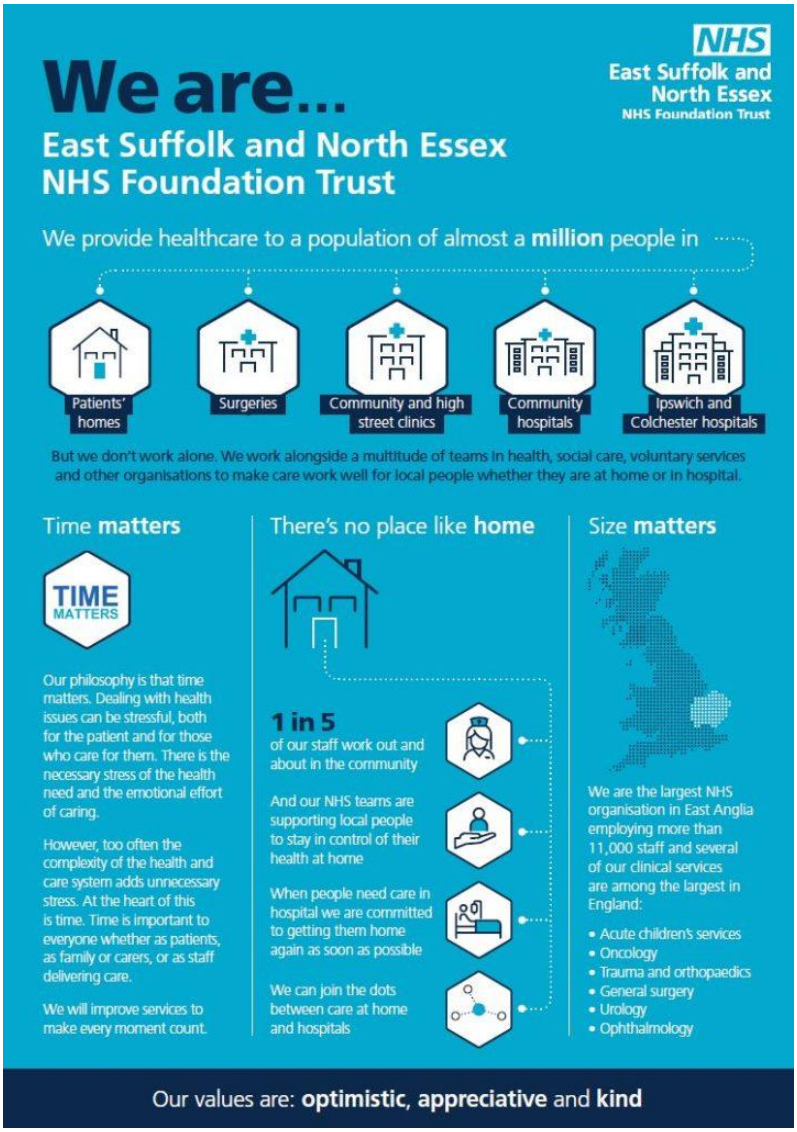
About us

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

We are an integrated Trust, delivering care from two main acute hospital sites in Colchester and Ipswich, six community hospitals and in patients' own homes. We provide a range of specialised services, such as spinal surgery and prosthetics.

In November 2024 the ESEOC opened, housed in the purpose-built Dame Clare Marx Building at Colchester Hospital. This is one of the largest centres of its kind in Europe and it means operations are less likely to be postponed. Patients won't have to wait as long for their surgery, so they can get back to living their lives, pain free, as soon as possible.

Our community health services operate in Aldeburgh, Clacton, Halstead, Harwich and Felixstowe community hospitals, as well as Bluebird Lodge near Ipswich.



Our activities are overseen by NHS England (NHSE) and by legislation. Our quality of care is assessed by the Care Quality Commission (CQC).

In an NHS Foundation Trust, there are three components:

- The membership community - anyone over the age of 16 living in our area can become a member for free; all staff are members unless they choose to opt out. This gives greater opportunities for staff and local people to get involved in how their local Trust operates
- Council of Governors (the Council) – the Chair of the Trust chairs the Council; 18 elected public governors, seven elected staff governors and 10 appointed governors representing local organisations
- Board of Directors (the Board) – Non-executive and executive directors, non-voting associate non-executive directors, and five non-voting Executive Directors.

The Trust is supported by operational decision making at the Executive Management Committee (EMC), the senior management level group in the Trust, advising the Board, Board committees and executive directors as required. EMC has operational oversight for performance, delivery against the targets and plans agreed by the Board and ensuring the safety and quality of services delivered to patients. It provides strategic leadership which includes supporting executive directors in the development of strategies, plans and targets for the consideration of the Board.

The structure of the Board and its Committees can be found within the Annual Governance Statement.

In 2024/25 we were one of the largest NHS organisations in the region and have an annual turnover of over £1.1 billion. We are one of the biggest employers in East Anglia and employed nearly 13,000 people on 31 March 2025.

Our strategy

This section provides a summary of what we intended to achieve in the last year, what we have achieved and our plans for the future.

Our strategy reflects national and local strategies and recognises our role as a major partner in the complex system of health, care and wellbeing services. By implementing our strategy, we will offer services that meet national standards and best practice, such as the Getting It Right First Time (GIRFT) programme and national institute for health and care excellence (NICE) standards. It will deliver our organisation's contribution to the NHS Long Term Plan, the Suffolk and North East Essex Integrated Care System (SNEE ICS) joint forward plan and Health and Wellbeing plans in Essex and Suffolk.

The Trust's Clinical Strategy 2024/29 is closely aligned to national and ICS strategies, recognising that we are part of a complex system of health and wellbeing services. We have a key role in this system to ensure that people receive high-quality, joined-up care. Our ambition is to offer the best care and experience, and to increase equity in health outcomes across our population.

ESNEFT's delivery of services is supported by five strategic objectives which guide our planning and investment:

The Trust's strategic plan comprises 12 director-led programmes that underpin and help deliver the Clinical Strategy.

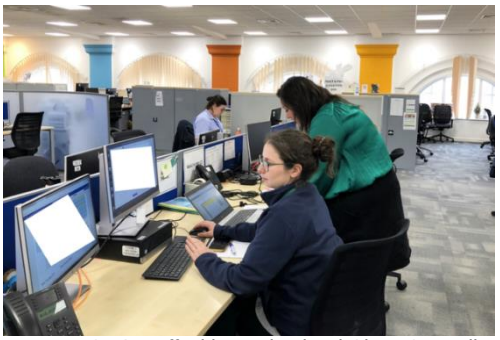
These programmes collectively drive the high-level improvement and sustainability work to better serve our patients and their families. In addition to making improvements, we are: providing care closer to a patient's home through virtual ward pathways, providing new and improved facilities through delivery of major estates development projects, reducing the impact of inequalities for our more challenged communities and the improvements made to support our workforce mean we are better placed to care for our patients.

Summary achievements in this year

In urgent and emergency care we have very considerably increased the numbers of patients discharged on the day of attendance, helping to return people to their normal lives as quickly as possible.

Our work on virtual wards - also known as Hospital at Home - continued very strongly; working with colleagues in community services; supporting patients with their care, without the need to travel to hospital.

Elsewhere in community services our UCRS (Urgent Community Response Services) performed highly; providing urgent care to people in their own homes which helps to avoid hospital admissions and enables people to live independently. By Christmas 2024, more than three quarters of all calls were responded to within two hours. Acceptance rates into UCRS have been significantly above the regional average.


UCRS staff with service lead Clare Cunnell

Improvements in the effective management and increased awareness regarding nutrition continue; exceeding our internal targets for ensuring patients receive appropriate nutrition and/or nutritional intervention by the middle of the year.

Our outpatient transformation work continues to improve services, meeting or exceeding the national targets for Patient Initiated Follow-Up – which gives patients and their carers the flexibility to arrange their follow-up appointments as and when they need them. Advice & Guidance, which provides primary care with continued access to specialist clinical advice, enables a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary visits to hospital.

Where patients are in the last days or weeks of life, we continue to improve care for them and those close to them, wherever they are cared for in the Trust. Our aim is to transfer them to their preferred place of care, in a timely manner. For those patients wishing to be transferred home we have exceeded our internal target to support this.

More information about the improvements we are making can be found in the Developing services for our patients

ESNEFT as an anchor institution

Anchor institutions are large public sector organisations which are rooted in place and connected to their communities, such as universities, local authorities, and hospitals.

Anchor institutions have significant assets and spending power and can consciously use these resources to positively benefit their communities.

We take this responsibility extremely seriously and the Board receives a report on progress up to three times each year. Our activities as an employer continue to grow. For workforce, we have agreed to sign up to the Charter for Local Anchor Institutions to address:

- Local recruitment
- Training, development and progression
- Health workplaces
- Volunteering, work experience and mentorship.

The Faculty of Education works with our partner higher education institutes and further education colleges across the ICS, including supporting the development and delivery of courses aimed at encouraging local people into healthcare careers. This includes activities such as the NextMedic programme and Next AHP (Allied Health Professionals) programme working in schools from year 9 onwards to support and inspire children into careers in allied health and medicine.

Some of our student nurses

We are the only organisation nationally that has run the pilot medical doctor degree apprenticeship in collaboration with Anglia Ruskin school of medicine and now have 50 undergraduate medical students enrolled in two cohorts. These future doctors have mainly come from the local region and have a focus on underrepresented communities with over 75% meeting the widening access criteria.

The faculty also oversees innovative and novel solutions to engaging our local communities such as the healthcare support worker apprenticeship academy model and Operating Department Practitioner (ODP) apprenticeship.

We hold career events for students and an annual careers fair at Colchester and Ipswich and provide work experience opportunities. We run master classes to introduce school children to careers in health and have interacted with over 1,000 school students and targeted disadvantaged areas and underrepresented community groups encouraging AHP roles, medical schools and showcasing simulation training equipment through our robotic surgery.

The focus on Career Start offers internships to school leavers with special educational needs further supported by the work with Essex Carers Limited helping adults with learning difficulties into meaningful employment.

A Diagnostic Training Academy has been set up in Clacton in partnership with Colchester Institute to take 133 local residents into training to prepare them for employment opportunities. This is a powerful example of what we are seeking to achieve.

Other highlights from this programme include:

- We are members of the SNEE ICB Procurement Anchor Group, and one issue discussed is embedding social value.
- We buy locally wherever possible from small and medium sized businesses
- During the procurement exercise for soft facilities management services, the tender included the requirement for bidders to state how, and to what extent, they would achieve the social value and sustainability objectives
- We continue to focus on the environment to reduce the impact of climate change, to encourage active and sustainable travel options and to promote environmentally sustainable practices – mor information can be found in the environmental matters section of this report.
- In maximising the use of our estate to support our staff, we are continuing to deliver the backlog maintenance requirements. The Clacton Site Transformation and Redevelopment (STAR) will significantly increase diagnostics activity and allows us to provide care closer to home for hard-to-reach communities, including outpatient appointments. This enables our patients to receive high quality healthcare in state-of-the-art surroundings

Clacton STAR

- We are developing the Ipswich Community Diagnostic Centre in the centre of the town
- We are increasing opportunities for local people to volunteer with us
- We are supporting our Armed Forces community.

Working within an integrated care system

We are part of the SNEE ICS. This is a partnership that brings together providers of NHS services with commissioners and local authorities and local partners. Together they collectively plan health and care services to meet the needs of the population.

The Integrated Care Board (ICB) was established as a statutory body from 1 July 2022, serving over one million residents in two counties. They plan and buy healthcare services for our population, with a budget of around £1.5 billion, which is set by NHS England. The ICB has delegated some authority to the three health and wellbeing alliances that operate in Suffolk and north east Essex to act on its behalf. This is to ensure that the needs of smaller, local areas are addressed. Their performance is judged by how well our health and care system as a whole is and working, including the health outcomes of our communities.

There are three areas within the ICS, called Alliances, in which health and care organisations work together to join up care for our communities. These also bring together partners from across the health and care system to form plans to tackle health inequalities and to improve the health and wellbeing of communities, covering West Suffolk, Ipswich and East Suffolk and North East Essex.

The Joint Forward Plan outlines how the ICB will plan and fund health and care services in Suffolk and north east Essex over the next five years. It strongly reflects the views of local people and communities and sets out a series of commitments that aim to deliver improved physical and mental wellbeing for the population. More information can be found in an Easy Read Executive Summary of the JFP and on the ICB website https://suffolkandnortheastessex.icb.nhs.uk/

ESNEFT's Chief Executive is one of three NHS partner members of the ICB, who bring the perspective, experience and knowledge of acute, community and mental health care services.

The Integrated Care Partnership (ICP) is a statutory joint committee which brings the ICB, local authorities and the wider community together. Our Chief Executive is also a member of the ICP. ICB/ICP updates are provided to the Board at every meeting.

A collective ambition of the SNEE ICS is to enable everyone to 'Live Well'. The ICB has defined its delivery priorities using the six domains of the Live Well model which also set out the six overall outcomes to be achieved:

1. Start Well – giving children and young people the best start in life
2. Feel Well – supporting the mental wellbeing of our population
3. Be Well – empowering adults to make healthy lifestyle choices
4. Stay Well – supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives
5. Age Well – supporting people to live safely and independently as they grow older
6. Die Well – giving individuals nearing the end of their lives choice around their care.

The six Live Well domains and their priorities aim to reduce health inequalities for our local population.

More information on our work on health inequalities can be found in the Reducing health inequalities section of this report.

As NHS England changes take effect and the landscape of ICBs changes during 2025/26, we will continue to be involved in and to support those changes with a focus on the care provided to our local community.

Provider Collaborative

The SNEE Provider Collaborative (SNEE PC), established in 2024, brings together West Suffolk NHS Foundation Trust (WSFT) and ESNEFT. Serving a population of over 1 million, the collaboration aims to improve patient outcomes amid rising demand and resource constraints. Strengthened governance structures ensure effective oversight, enabling both Trusts to work closely and drive impactful change.

A key milestone was the launch of ESEOC on 11 November 2024. The centre has exceeded expectations, treating over 100 patients on its first day and introducing semi-elective ambulatory trauma care. Collaborative clinical initiatives have also focused on shared pathways, including the repatriation of paediatric urology patients from WSFT to ESNEFT, easing pressure on services and addressing child health inequalities.

Efforts to enhance efficiency and productivity include joint cost improvement projects (CIP), service consolidation, and automation. Digital integration has supported ESEOC's implementation, ensuring seamless clinical data transfer between Trusts, while a contract register integration is set to drive further efficiency gains in 2025/26. A memorandum of understanding has been developed to reinforce collaborative governance, with its launch in summer 2024.

Looking ahead, work planning for 2025/26 aligns with the new 10-year NHS plan, guided by the SNEE ICB's sustainability review. The collaborative will continue advancing shared CIP plans and system-wide efficiencies. With ongoing stakeholder engagement and governance, the collaborative remains committed to its role in providing strategic oversight and guiding the programme into 2025 and beyond.

Stakeholder relations

In a large Trust, with a number of significant development and improvement projects underway, it's vital that we continue to foster relationships and collaborate with our external stakeholders.

- **Engaging with democracy**

Ipswich Mayor Elango Elavalakan joined us to mark the opening of the new £9.1million theatre development at Ipswich Hospital in July 2024. The surgical hub is used for a variety of procedures, including general surgery, ear, nose and throat cases, oral surgery and urology. With three specialist theatres, there is also a same-day admissions ward, which means many patients are able to go home on the same day to recover.

In November 2024 we opened our Orthopaedic Centre at Colchester Hospital, ESEOC. While the centre was being built, and also since its opening, we have continued to engage with patients, staff and our local councils including the Essex and Suffolk Health Overview and Scrutiny Committees and Health and Wellbeing Boards, providing updates about the progress of the centre and how it is performing. We hosted a tour of the new building for councillors from Colchester City Council and Tendring District Council who also had a briefing with our Chief Executive and some of our executive leaders.

- **MP visits**

Our Chief Executive continues to liaise with MPs within our area and has held a number of visits and briefings over the last year with Jack Abbott (Ipswich), James Cartlidge (South Suffolk), Pam Cox (Colchester) and Nigel Farage (Clacton)

- **Attendance at patient and public forums**

Listening to and working with the people who use our services, as well as their loved ones and carers is crucial to making sure we're meeting the needs of those who need us. We continue to work in partnership with colleagues from across the system through the Integrated Care System People and Communities Programme Board and also work with Essex and Suffolk Healthwatch organisations.

During 2024/25 we have not been required to discharge our duty to involve patients and the public through any public consultation work.

Principal risks

A system of risk management and control is in place. The Board provides leadership as part of the overall governance structure. This is supported by the Board's Audit and Risk Committee which has responsibility for oversight of risk management and the systems of internal control.

All committees regularly report to the Board on the assurance received at their meetings and where there is a lack of assurance or risks to achieving our objectives.

The Board Assurance Framework (BAF) has continued to develop. Two of the 11 strategic risks are reserved for the Board with the remainder aligned to a Board committee and owned by an executive director. Committee reporting, additional assurance and controls are reflected in the BAF, presented to the Board on three occasions during the year.

A full description of the risk and control framework, the risk management policy, the Trust's risk appetite agreed by the Board and the strategic risks is included within the Annual Governance Statement.

Going concern

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

The Department of Health and Social Care Group (DHSC) Accounting Manual 2024/25, directs that non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

There are reasonable expectations that the services currently provided by ESNEFT will continue to be provided in the foreseeable future in the public sector and that adequate resources will be provided to the Trust for that end. There are no known material uncertainties or planned events which would raise doubts over these expectations.

Further considerations taken into account by management in making this assessment are the Trust's income and expenditure plan for 2025/26, which is to deliver a break-even position, and the current cash position of the Trust. The Trust's cash plan for 2025/26 is not reliant on DHSC funding for cash financing with a forecast cash balance of £47.8m at 31 March 2026.

The Trust reported a £3.5m surplus in 2024/25, as per the reporting criteria set by NHSE.

Activity and performance analysis

Our Trust priorities for 2024/25 were:

- Work to bring in Epic, our new patient electronic records system. This will transform how we work and care for patients, improving staff and patient experience every single day
- Making Time Matter – looking at clinical transformation in a different way and making sure we embed our Time Matters philosophy
- The fundamentals of care. Committing to the best possible care, underpinned by safety and quality, for all patients, every day. The other two priorities will help us with this.

We provide a range of services, and these are the numbers of patients we have treated this year:

	2024/25
Outpatient attendances	Total Attendances: 1,043,828
Emergency department (A&E) patients (includes urgent treatment centre)	337,452 Main EDs and UTCs (Reported) (174,617 Main EDs only) 45,537 Clacton UTC 82,061 Colchester UTC 36,652 Ipswich UTC and primary care streaming 162,835 urgent treatment centres only
Inpatient and day case admissions	Day cases: 102,114 Elective admissions: 11,538 Non-elective admissions: 115,672 Total overnight: 127,210
Babies born	6,488
Community hospital admissions	1,473 North East Essex Community Services 1,101 Ipswich and East Suffolk Community Services 2,574 ESNEFT
Community contacts	444,577 North East Essex Community Services 416,537 Ipswich and East Suffolk Community Services 861,114 ESNEFT

We have developed an Accountability Framework (AF) oversight and escalation model as its primary performance management regime. This framework aims to align the delivery of all clinical and non-clinical operational performance targets, quality indicators and outcome measures. The purpose of the framework is to:

- Ensure that the Trust has effective systems and processes in place to provide assurance to the Board and our stakeholders that the organisation is performing to the highest of statutory and regulatory standards
- Develop the business intelligence of the Trust to inform capacity-demand planning and service delivery improvement
- Measure productivity and efficiency increases enabling us to deliver cost improvement and transformation programmes
- Support the delivery of objectives
- Provide assurance that the Trust is achieving best value for money in its use of resources.

The performance indicators are grouped in the following six domains:

- **Safe** – protected from abuse and avoidable harm
- **Effective** – care, treatment and support achieves good outcomes, maintain quality of life and is based on best available evidence
- **Caring** – that staff involve and treat you with compassion, kindness, dignity and respect
- **Responsive** – services organised so they meet your needs
- **Well-led** – leadership, management and governance make sure of providing high-quality care based around individual needs, encourages learning and innovation, and promotes an open and fair culture
- **Use of Resources** - how well the organisation has been using resources, measured by financial performance and metrics such as those included in Model Hospital.

This framework reflects the fact that decisions need to be made as close to the patient as possible but that these decisions need to balance the essential priorities of clinical quality, delivery, patient experience, staff satisfaction and financial sustainability.

The AF Policy, on which the framework is based, was approved in October 2022 by EMC and was considered by the Board's Performance and Finance Committee. This enabled the committee to provide assurance to the Board on the procedures in place that underpin the information and data presented. The policy is due for review during 2025/26.

The metrics included within the AF are reviewed annually and approved by EMC. These are presented to the Performance and Finance Committee for assurance.

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

The Board reviews performance data each month using the integrated performance report. Detailed debate and constructive challenge takes place at the monthly Performance and Performance Committee and a key issues report is presented to the Board, providing alerts or escalation as required.

This is a summary of what we have achieved in 2024/25.

	Standard	Performance	National Performance
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	80.20%	N/A
All cancers: 28-day wait for diagnosis for urgent suspected cancers	80%	76.27%	77.29%
All cancers: 62-day wait for the first treatment from national screening service referral	90%	78.80%	64.81%
All cancers: 62-day wait for the first treatment from urgent GP referral to treatment	75%	69.68%	63.87%
All cancers: 31-day wait from diagnosis to first treatment	96%	92.99%	91.86%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days.	100%	70.24%	77.25%
Percentage of patients on an incomplete pathway with a maximum of 18 weeks waiting time	92%	58.00%	55.90%
MRSA	0	5	N/A
Incidence of Clostridium difficile infection (due to lapse in care)	0	3	N/A

Data sources: cancer national return, RTT national return, AF, QMCO national return

	National performance
Emergency department (A&E) four-hour standard	
The Trust recorded a performance of 75.2% against the national standard of 75%.	73.4%

Workforce

Our work to encourage and help support people into employment at ESNEFT has seen huge growth over recent years and is now recognised regionally and nationally as an example of excellence.

The People Strategy was revised and approved by the Board in November 2024, and the significant achievements across each of the strategic objectives were reviewed:

- Workforce planning, resourcing and retention
- Staff experience
- Education, training and leadership development
- System working.

Quality

Our priorities for 2024/25 were:

- Clinical effectiveness: To increase the number of patients actively involved in *shared decision making*.
- Patient experience: To continue to support patients by *Making Every Contact Count*.
- Patient safety: To improve the care and management of patients who have dementia, their families and their carers, wherever they are cared for in the Trust – *end of life care*.

The Trust has a sustained Quality Programme, inclusive of quality priorities and this consists of:

- Sepsis & Deteriorating Patient
- Falls
- Nutrition
- Maternity
- Dementia
- Continence
- Infection Prevention and Control
- Mental Health
- End of Life Care
- Getting it Right First Time (GIRFT)
- Quality Improvement
- Healthcare Inequalities
- Medication Safety
- Shared Decision Making
- Making Every Contact Count

Looking ahead to 2025/26

The priorities and operational planning guidance sets out the key national priorities to improve patients' outcomes:

- Reduce the time people wait for elective care
- Improve A&E waiting times and ambulance response times
- Improve patients access to general practice and improve access to urgent dental care
- Improve patient flow through mental health crisis and acute pathways and improve access to children and young people's mental health services.

To achieve these priorities, ICBs and providers must work together, with the support of NHS England to:

- Drive the reform that will support delivery of the immediate priorities and ensure the NHS is fit for the future
- Live within the budget allocated, reducing waste and improving productivity
- Implement reforms to support the immediate priorities and prepare the NHS for the future
- Maintain collective focus on the overall quality and safety of services.

Our ambitions for the next year continue to be grouped into four categories, which includes our quality priorities to build and sustain improvements on the Fundamentals of Care Framework. A comprehensive account of our work in addressing quality of care can be found in the Quality Account 2024/25.

Trust objectives 2025/26 - Plan on a page

Service Delivery

- Meet national ED four-hour performance standard – 78% (March 25)
- 50% improvement on patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25.
- Reduce avoidable ambulance conveyances and handover delays - Work towards delivering hospital handovers within 15 minutes, with joint working arrangements that ensure that no handover takes longer than 45 minutes.
- Improve the percentage of patients waiting <18 weeks for treatment to 65% by March 26.
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026.
- Reduce the proportion of people waiting >52 weeks for treatment to less than 1% of the total waiting list by March 2026.
- Improve performance against 62-day cancer standard to 75% by March 2026.
- Improve performance against 28-day cancer Faster Diagnostic Standard to 80% by March 26.

Quality

- Clinical outcomes - Oversight of top 3 highest priority outcomes for each clinical service.
- Continue to implement the Maternity single delivery plan released in 23/24; to be measured via action to ensure care is provided in line with best clinical practice via local outcome date. Progress to sustainability and exit from the Maternity safety support programme (MSSP).
- Continue to extend the health inequalities programme; measured via the making every contact count initiative (offer of support in participating OPD clinics) ->=80% and develop plans to extend to inpatient settings.
- Continue to improve the care we deliver in our inpatient care settings supported by and demonstrated through improvements in our Accrediting Care at ESNEFT programme. Stepwise improvement from the Ward accreditation programme. To be reviewed quarterly.
- Embed the use of TEP and ReSPECT tool.
- Reduction of restrictive practise. Evidence through reduction of use of security, 1 to 1 care and ETOC.

Continue to improve our care to those at the end of their life via timely transfer to preferred place of care –<5.5 days to patients' home or <8.5 days to care home.

Workforce & OD

- Increase productivity by fully utilising existing staff and introducing new roles; monitored through voluntary turnover - <=7%.
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending
- Reduce bank use, the Trust is expected to deliver a minimum 10% reduction.
- Continue to grow and develop our health and wellbeing programme; to be monitored via staff absence - <=4%
- Improve staff engagement; to be monitored via staff survey - <=50% response rate
- Continue to maximise student / trainee / HEE and ethical international recruitment including apprentices; to be monitored via apprentices in post - >=500.
- Continue to improve percentage of BAME staff in post band 6 + - >=22%.
- Appraisal and mandatory training compliance to be >= 90%
- Continue to improve vacancy rate - <=3.5%

Finance, Capital & Charity

- Deliver break-even revenue position; monitored via external plan
- Deliver recurrent cost improvements of £43.9m (this includes £4.8m of EPR benefits) – 90% of plan by Q1.
- Increase productivity; noncash releasing productivity to be measured via cost improvement team – 2% of turnover.
- Remain within CDEL capital plan; monitored via external plan
- To embed new developments & ensure agreed financial objectives are delivered; to be measured via the financial contribution to the organisation
- Maintain EPR Go-Live Timeline, to be monitored via go-live readiness and post go-live optimisation and benefit realisation.
- Maintain adequate cash to ensure business continuity; to be monitored via external plan
- To deliver charitable funding to the Trust in 2025/26 >£3m
- Development of the new Trust Estates and Property Strategy; Risk prioritised backlog maintenance plans.

Environmental matters

Climate change is a significant crisis facing the global community, and one the UK will need to continue to confront amid warmer winters and hotter summers, plus more variable rainfall and more severe storms.

Sea levels are rising by approximately 4 millimetres per year[1] around the UK coastline, increasing the risk to buildings and infrastructure close to the shoreline. Extreme weather – flooding, storms, heatwaves – already cause significant disruption in the UK every year, so we should not underestimate the challenges that a more extreme climate will have on our lives, the economy and our environment.

As a publicly funded organisation, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health, both in the immediate and long term, even in the context of the rising cost of natural resources.

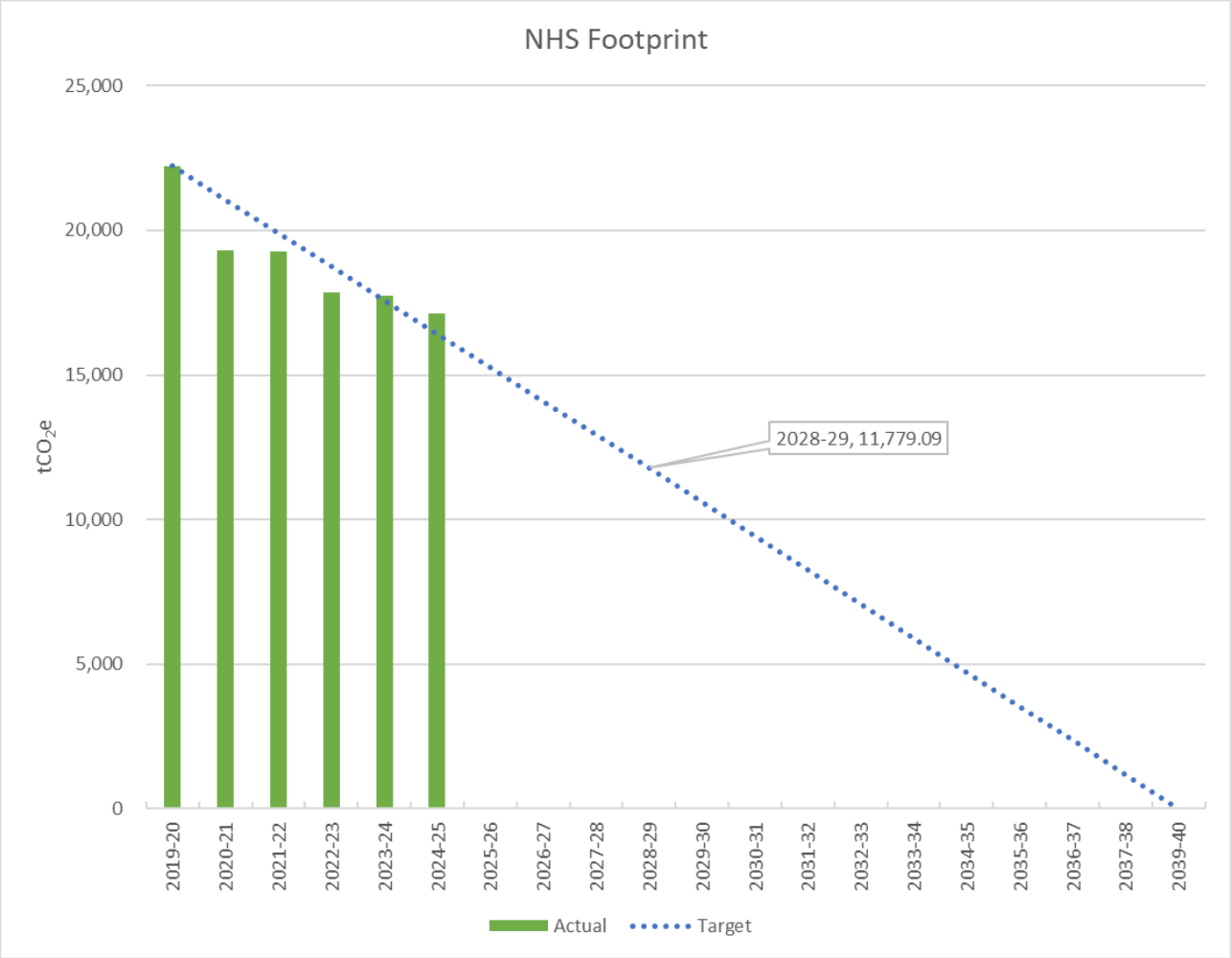
In January 2024, the Board approved the second iteration of our Green Plan 2024/27. It outlines and reaffirms our commitment to a Carbon Net Zero future, provides an update on what we've achieved so far and our strategy for reaching that goal. The strategy sets out the approach and aims to take ESNEFT towards Net Zero. It also recognises opportunities to maximise environmental benefit, improve health outcomes, reduce costs and ultimately make our Trust an exemplar for sustainable healthcare, making it an attractive place to work and to receive treatment. A revised plan is due to be considered and published in July 2025.

Summary of progress

In addition to the progress made through the introduction of the Green Plan we have continued to be active members of Colchester Travel Plan Club, the National Performance Advisory Group groups for car parking and sustainable travel and waste whilst also providing resource to chair the regional HefmA Energy Group.

As can be seen in the following graph, having seen a continued decline in the NHS Footprint Emissions for ESNEFT, the 2024/25 carbon emissions have risen again to those seen in 2022/23. This is due to an increase in physical footprint and therefore, if based against our 1990 physical footprint, we continue to make good progress. There will be additional actions taken in the future to return the figures to their original trajectory. Highlighted on the following graph is the interim target for 2028/29.

[1] State of the UK Climate 2021 - Kendon - 2022 - International Journal of Climatology - Wiley Online Library



Task Force on Climate-Related Disclosures (TFCD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

These disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under these requirements as they are computed nationally by NHSE.

The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24. This disclosure is provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Good governance is crucial for the effective implementation and oversight of initiatives like the Green Plan. This importance is underscored in the various roles and structures outlined for its execution. The structure and roles of the various groups involved in implementing and overseeing the Green Plan are as follows:

- **Trust Board -** The Board of Directors maintains responsibility for reviewing and approving the Green Plan, providing strategic oversight and support where necessary.
- **Sustainability Steering Group -** This group meets on a quarterly basis and is responsible for ensuring that the Green Plan is transposed into detailed action plans which are maintained, implemented and reported against, and that all projects are on track. It includes a range of stakeholders associated with the net zero categories detailed in this document.
- **Net Zero Category Delivery Groups -** Each stakeholder responsible for one of the categories in the Green Plan is encouraged to establish their own sub-group or to integrate sustainability into an existing one. These groups will further explore the actions recorded in each dedicated section, provide measurement against key performance indicators and feed back to the steering group.
- **Green Champions –** Staff members who are passionate about climate change and transforming the NHS into a sustainable healthcare system. They meet virtually monthly, with a different theme discussed each time. This network enables staff to have their say and to be directly involved in our journey to becoming a more sustainable Trust.
- **Sustainability sub-groups -** These groups represent staff interests in relation to specific work areas and have no formal reporting lines, for example the Bicycle User Group.

We also ensure appropriate governance processes are in place through the following:

- **Business cases** – All business cases are required to consider their impact (positively or negatively) on the Net Zero strategy, reviewed within the Estates Strategic Programme Group and Investment Group as part of the overall assessment.
- **Adaptation -** Events such as heatwaves, cold snaps and flooding are expected to increase because of climate change. To ensure that our services continue to meet the needs of our local population during such events, we have a dedicated responsible person for ensuring its consideration, managing the risk register as appropriate and the development of a number of policies and protocols in partnership with other local agencies.

Reducing health inequalities

Health inequalities are the “preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies” (NHSE).

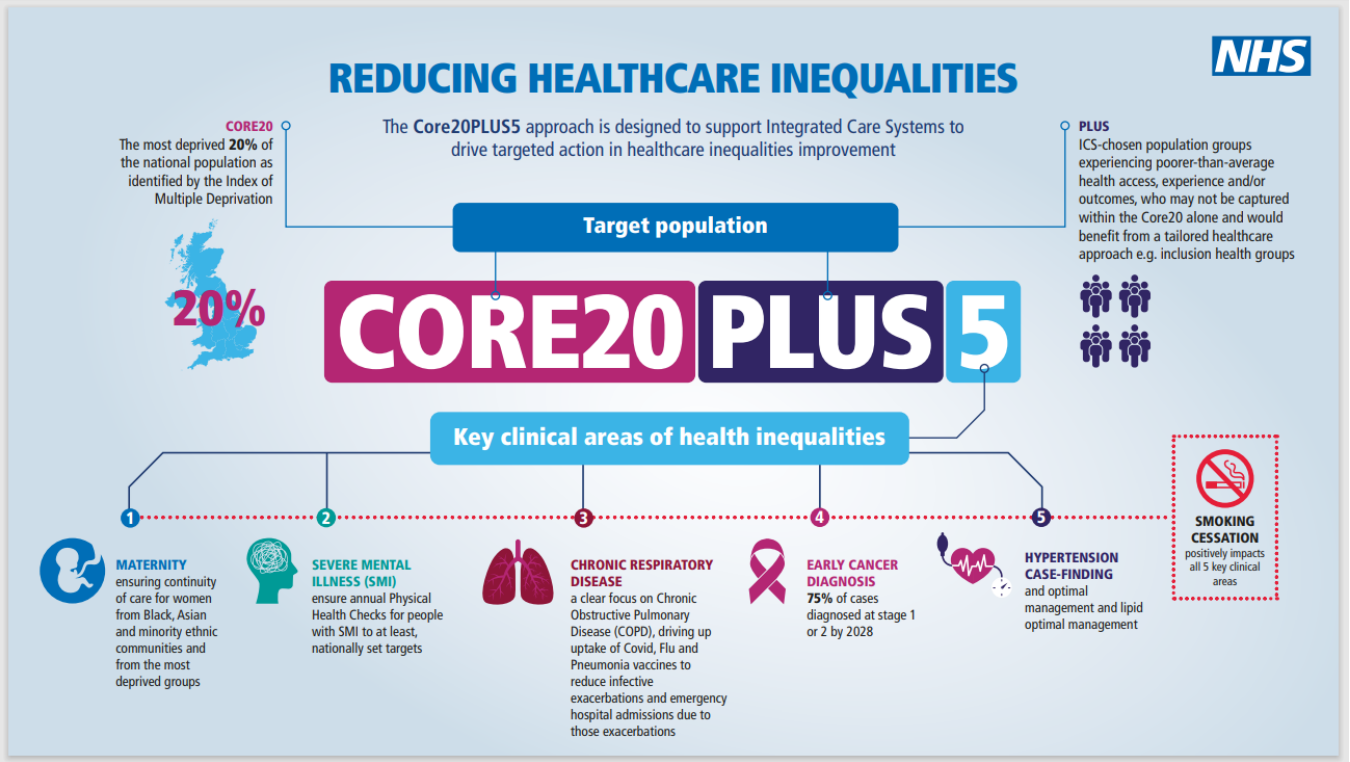
In January 2023, ESNEFT launched its four-year Health Inequalities Strategy which aims to improve the health of local people and equity of access to our services.

This is supported by four key objectives:

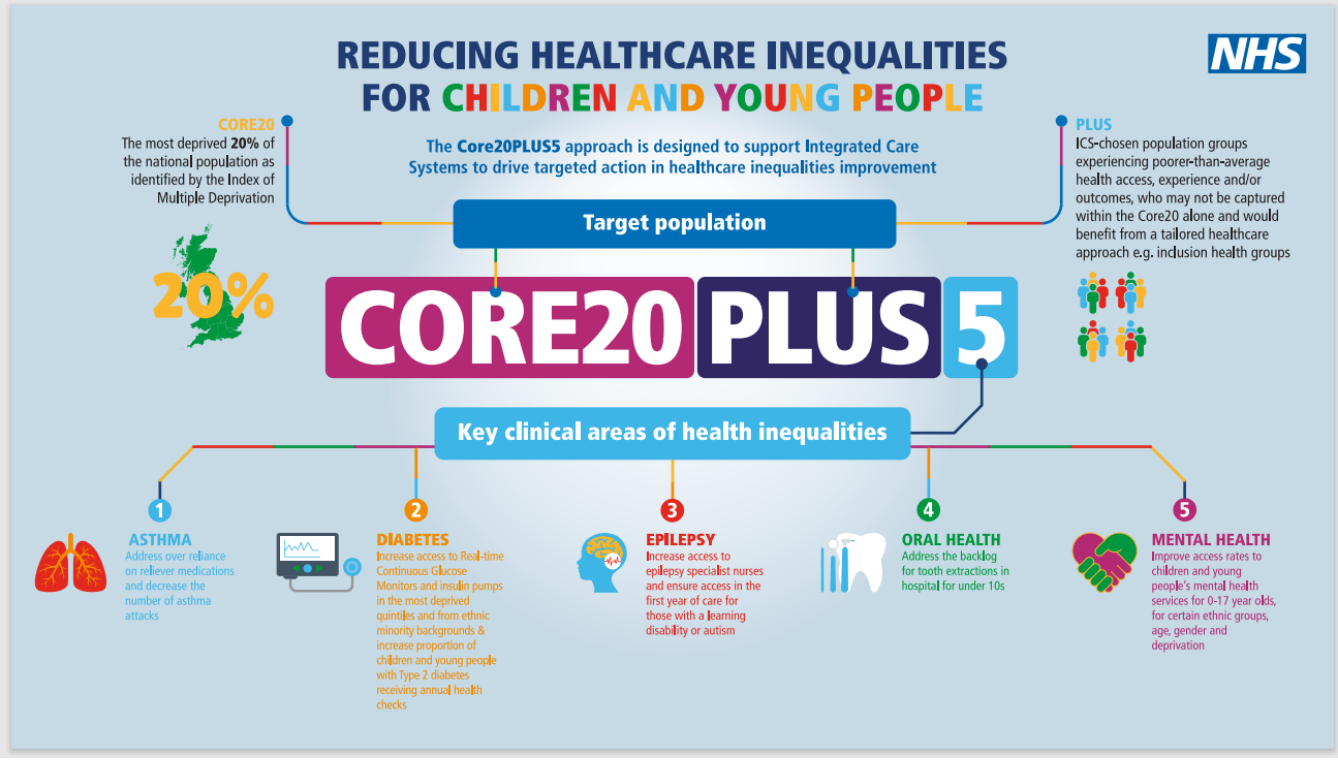
- Get everyone involved in equity
- Identify and monitor health and healthcare inequalities using data
- Understand the causes of inequities and barriers resulting in them
- Create change together with our partners and communities and measure its impact.

The priority areas, defined by the NHS Long Term Plan, have set the system-wide context for the Core20PLUS5 approach to support the reduction of health inequalities at both the national and ICS level using population health management approaches.

CORE20PLUS5 Adults



CORE20PLUS5 – Children and Young People



A Health Inequalities Programme Group was established to identify local inequality priorities and to take action to address these, working with patients, community groups and system partners. The aims and ambitions of this group are:

- To work with community partners and the ICS to align approaches and provide tailored support to our communities
- To implement population health management and personalised care approaches to improve health outcomes and ensure equitable access to our services within our localities
- To promote self-care and keeping well to our patients and consider how we can reduce health inequities that have been magnified by the Covid pandemic.

To promote risk factor management and improve equity of access to our services, we have:

- Implemented an inpatient tobacco treatment service. There have now been over 1,548 patients referred to the service, translating into just below a 50% quit rate at 28 days. The service has evolved to include pre-operative assessment patients and a dedicated tobacco dependency advisor to support staff, parents and carers. So far, there have been 114 referrals into the staff service translating into a 65% quit rate. Maternity teams have also established a tobacco treatment service to reduce "smoking at birth" rates. This has exceeded the national targets.

Feedback on the Tobacco Treatment Service:

> *"I've smoked for nearly 14 years and tried to give up probably over 20 times and never managed it. The Tobacco Dependency Advisor is truly made to do this job and I put it all down to him. I'm still early in my journey (just over 4 weeks) but he's given me all the tools to succeed and to have someone believing in me again was irreplaceable."*

> *"The Tobacco Dependency Advisor was so helpful, my wife struggled to quit and the TDA never gave up on her and helped me to support her as she is not really mobile. She gave me so many ideas and together we got my wife off the cigarettes. This is a great service."*

- Reviewed Did Not Attend data by postcode and developed plans to take care closer to home where possible, for example a diabetic eye clinic in Clacton. A discounted rate for patients using the Park and Ride at Colchester has been secured indefinitely and a business case to purchase another Hospital Hopper bus has been written.
- Responded to children and young people obesity rates in our areas of deprivation by developing and completing our second 20-week healthy eating programme "Nourish" in Central Ipswich. A further programme is planned for Clacton and Harwich in 2025/26.

- Recruited two asthma outreach nurses who have commenced carrying out asthma reviews and putting asthma management plans in place for children and young people in our areas of deprivation, within central Ipswich and Tendring. A training package has also been developed for delivery in schools.
- Following the delivery of pictorial inpatient menus for all wards, a mealtime volunteer service was developed. 21 volunteers have been recruited with five of these now in post working alongside ward staff. The remainder are in training.
- Continued the frailty management service in Clacton working with Ranworth Primary Care Network.
- Continued with the "Healthy Hearts" project with GP Primary Choice Ltd to reduce cardiovascular events in North East Essex by identifying hypertension and switching to effective cholesterol treatments.
- Worked with system partners to deliver six engagement days within our communities to raise awareness of screening, smoking cessation and promoting healthy eating. The paediatric team from the Community Immunisation Service (Hertfordshire Community NHS Trust) also joined us to carry out vaccinations to children.

91 of 100 attendees said that "events like these had positively influenced their decisions to go for screening, health checks and vaccinations".

To support patients and those close to them we have adopted Making Every Contact Count (MECC). This is an approach to behaviour change that uses the millions of day-to-day interactions with organisations and people to support them in making positive changes to their physical and mental health and wellbeing. We have used MECC to support patients around emotional wellbeing, healthy eating, finance, housing and carer responsibilities.

MECC has now been rolled out to over 280 outpatient clinics, with over 46,000 offers of support being made and 7,400 referrals to wellbeing services. Other teams signing up to MECC this year include Emergency Departments, the Urgent Treatment Centre, ESEOC, Ophthalmology, and Women's and Children's.

A training module has been developed and MECC awareness training delivered to 259 members of staff since August 2024.

General health inequalities awareness sessions have also been developed and delivered across ESNEFT teams. These have been designed to inform and empower leaders and frontline staff to consider health inequalities when they are developing divisional plans. The sessions are supported by the Tobacco Dependency Advisors highlighting to teams the importance of making tobacco treatment referrals and how to do this.

The Health Inequalities team have been working with Epic colleagues to support the build of the Determinants of Health element of the new electronic patient record, ensuring it meets the needs of our programme delivery.

Relationships have been built with our numerous community groups including African Families in the UK, Ipswich Community Media's Integration and Romanian Community Teams and Summit Mental Health Charity, whom we hope to work collaboratively with over the coming year. We have collaborated with the Castle Hill foodbank in Ipswich to deliver cooking demonstrations utilising affordable, fresh and healthy ingredients. These sessions were delivered by ESNEFT chefs.

Financial performance

The Trust's accounts for 2024/25 have recorded a deficit of £38.6m. This includes a significant impairment of assets of £43.8m which has no cash impact.

	2024/25 £m	2023/24 £m
Operating income	1,219.7	1,070.3
Operating expenses	(1,243.9)	(1,069.8)
Operating deficit	**(24.2)**	**0.5**
Non-operating costs	(14.4)	(12.4)
Deficit for the year	**(38.6)**	**(11.9)**

The Trust has an annual financial control total (plan) set by NHSE. For 2024/25, the target was to achieve a £0.25m surplus or better. During the year the Trust was also requested to increase its surplus to assist with system wide pressures.

When measuring financial performance against this control total certain items are excluded, e.g. capital donations and impairments. After adjusting for these items, the Trust met its control total and delivered an increased surplus of £3.5m.

	2024/25 £m	2023/24 £m
Surplus/(deficit) for the year	**(38.6)**	**(11.9)**
Add back all I&E impairments	43.8	11.1
Remove capital donations and grants	(1.2)	0.0
Adjust for application of IFRIC 12 to PFI costs	(0.6)	2.0
Remove impact of DHSDC centrally procured inventories	0.1	0.1
Adjusted financial performance surplus	**3.5**	**1.3**

Financial improvement
Throughout the reporting year the Trust has been active in delivering efficiency plans and for 2024/25 achieved savings of £22.7m. £12.7m of these efficiencies provided recurrent benefits. All efficiencies must pass a quality assessment to ensure no adverse impact on patient care.

Cash management
The Trust has maintained a strong cash balance throughout the year. At year end the timing of capital cash funding has enhanced this position to a closing cash balance of £62.1m (compared to £79.3m at 31 March 2024)

Improving our assets (capital expenditure)
ESNEFT invested £78.9m in improving, maintaining and developing our asset base during 2024/25.

- £54.3m on maintaining and enhancing both hospital sites, including the Clacton Community Diagnostic Centre, the development of a new ED/UTC at Ipswich Hospital and the Dame Clare Marx Centre at Colchester
- £11.4m on medical equipment
- £4.9m on enhancing the Trust IT infrastructure, in particular the Electronic Patient Record (EPR).

Overseas operations
The Trust has no overseas operations.

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

Financial outlook

The Trust has developed a plan for 2025/26 which was submitted to NHSE on 30 April. This plan was constructed in line with current national NHS planning guidance and forecasts the delivery of a breakeven position.

Cost improvement programme

It is our ambition to deliver a financial break even position in 2025/26. To achieve this, it will be necessary to deliver a cost improvement saving of £43.9m. This is 3.6% of the Trust's operating expenditure. Plans have and are being developed to achieve these cost improvements.

Cash funding

The Trust is not planning to be reliant on DHSC funding for cash financing.

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

Long term planning

A major restructure of the NHS's central bodies has recently been announced, in March 2025, as part of a fundamental reset of the financial regime to support the future sustainability of the NHS's finances and its ability to deliver its key commitments. The changes include:

(1) 50% cuts to ICB running costs to be delivered by the third quarter of 2025/26, October 2025

Whilst emphasising that ICBs have a critical role to play in the future as strategic commissioners, with this central to realising the ambitions that will be set out in the 10 Year Health Plan, the new NHSE leadership team have confirmed that ICB costs are to reduce by 50%. This has led to plans to greatly consolidate the number of ICBs - currently there are 42 ICBs

(2) The integration of the DHSC and NHSE - essentially the abolition of NHSE.

(3) Reversing corporate cost growth in NHS providers.

Although further detail is still awaited, longer-term plans for the NHS have also been outlined in the NHSE publication Working together in 2025/26 to lay the foundations for reform, 1 April 2025:

- the intention is to move to a medium-term approach to planning
- greater transparency in relation to funding. This includes moving back to a ‘fair shares’ allocation policy over time, while unravelling some of the complexities that now exist around money, such as the removal of deficit funding
- focus on more of a devolved, rules-based system that is built on strong Board accountability
- a net surplus to be targeted in future so that deficit reduction is no longer the focus of leadership energy, instead creating the managerial capacity to concentrate on quality, including wider population health, access and leading organisations and local systems
- ICBs have a critical role to play in the future as strategic commissioners and this will be fundamental to the achievement of the ambitions that are to be outlined in the 10 Year Health Plan
- the 10 Year Health Plan will set out the key components of an operating model that is rules-based, provides earned autonomy and incentivises good financial and operational performance. It is also intended to reset and restore the focus on quality
- developing and strengthening commissioning, where commissioners and providers, where possible, jointly agree on affordable activity levels to meet key standards at the start of each year.

It is reasonable to assume (and the Trust is) that the core principles of the current ICB and system finance business rules will persist as a minimum requirement; and the wider SNEE ICS and Trust will be expected to adhere to them.

NHS foundation trusts were intended to operate on a similar basis to commercial organisations, so they must operate effectively, efficiently and economically and remain a going concern.

The Health and Care Act 2022 introduced a new requirement for NHS trusts and NHS foundation trusts, with their partner ICBs, to not exceed the revenue and capital spending limits set by NHSE.

The requirement that, at the national level, the DHSC must ensure that capital expenditure does not exceed the funds allocated to it for capital projects by Parliament - the capital departmental expenditure limit - means that capital expenditure has been constrained for all NHS providers.

The key business rules therefore that the Trust will plan to achieve are:

- Revenue resource use. Duty to act with a view to ensuring that the revenue resource use limit set by NHSE is not exceeded (applicable to the wider system too)

- Capital resource use. Duty to act with a view to ensuring that the capital resource use limit set by NHSE is not exceeded (applicable to the wider system too)

- Breakeven duty (achieve revenue financial balance). Objective to break even – that is, duty to seek to achieve organisational and ultimately system financial balance.

In terms of revenue performance, the guidance detailed above suggests that the break even duty may even have to be bettered, with surpluses required or at least encouraged. Clearly this will be challenging to achieve, but there is some optimism that extra money could potentially flow to the wider system at least. As part of the 'Working together' publication, NHSE have also published detail of distance to fair shares allocation by system. This shows that SNEE ICS is 2.9% 'under target', a value of £79.9m including specialist commissioning. Although it is not clear what element of this funding would potentially benefit the Trust, it does show that additional monies can reasonably be expected for the system given the commitment to returning to a fair shares distribution of monies.

The Trust recognises the importance of medium and long-term planning for both revenue and capital in supporting its financial sustainability. It provides an early indication of emerging risks and opportunities that the Trust can then act upon. Consequently, the Trust has developed a long-term financial model, which is used to project future revenue and capital scenarios based on key assumptions such as price inflation and activity growth. To ensure that these underlying assumptions are as robust and realistic as possible the Trust actively and frequently engages with both system, regional and national colleagues so that the most up-to-date information is used.

Post year end events

There have been no important events since the end of the financial year affecting the Trust.

Nick Hulme
Chief Executive
26 June 2025

Accountability Report

Directors' report

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

Our Board of Directors – its role

As a unitary board, the non-executive directors share responsibility with the executive directors for ensuring that the right resources are in place to meet the objectives set. Collectively the Board has responsibility for:

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

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

During the latter stages of 2024/25 the constitution was reviewed and was approved by the Council in March 2025 and by the Board on 3 April 2025. Two amendments were made:

- To the definition and the value attributable to a significant transaction. This was increased to reflect the Trust's £1.1bn annual turnover with the revision of existing text and inclusion of additional explanation. Current legislation allows Trusts to locally define what constitutes a significant transaction and this should be clearly defined in the constitution and known to governors.
- That the Public Constituencies were reduced from five to three, covering the following areas: the County of Essex, the County of Suffolk and All other areas of England.

As described at Standing Order 6.2, in an emergency or should an urgent decision be required, powers are exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors.

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

The Board takes active steps to ensure it interacts appropriately with the Council. Governors attend regular informal meetings with the Chair, two governors are identified to observe each Board assurance committee and governors are encouraged to attend the Board meetings held in public.

Non-executive directors are invited to attend Council meetings. The Chief Executive or Deputy Chief Executive and the Director of Governance attend every meeting. Other members of the executive team are invited to present on specific issues and are welcome to join the meetings held in public as diaries allow.

Disagreements between the Board and the Council are resolved through seeking to achieve informal resolution in the first instance, following which a formal process will be taken which involves a resolution for discussion at a Board meeting. This has not been required during 2024/25.

Appointment and composition of the Board

The Chair leads both the Board and the Council, ensuring that the Board and governors work together and there is an accurate record of decision making.

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

The Board comprises a Chair, seven further non-executive positions and seven voting executive directors. The Council appointed the Chair and other non-executive directors in accordance with the constitution and in line with paragraphs 19(2) and 19(3) respectively of schedule 7 of the National Health Service Act 2006. They were appointed by the Council following external recruitment. In accordance with the requirements of the Trust's constitution, these appointments and reappointments were approved by the Council.

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

Members of the Board during this year were:

Name	Title
Helen Taylor	Chair
Nick Hulme	Chief Executive
Eddie Bloomfield	Non-executive director – to 31 October 2024
David Eagles	Non-executive director – from 1 December 2024
Mike Gogarty	Non-executive director
Shane Gordon	Director of Strategy, Research and Innovation
John Humpston	Non-executive director
Hussein Khatib	Non-executive director
Dr Tim Leary	Interim Chief Medical Officer – from 12 August 2024
Adrian Marr	Director of Finance; appointed Deputy Chief Executive 8 January 2025
Mike Meers	Director of Digital, Logistics and Operations - Ipswich
Mark Millar	Non-executive director and Deputy Chair
Catherine Morgan	Interim Chief Nurse – from 1 July 2024; substantive from 1 November
Kate Read	Director of People and Organisational Development
Karen Sinnott	Non-executive director
Richard Spencer	Non-executive director and Senior Independent Director
Emma Sweeney	Acting Chief Nurse – to 12 April 2024
Dr Angela Tillett	Chief Medical Officer/Deputy Chief Executive - to 11 August 2024
In attendance: non-voting	
George Chalkias	Director of Governance
Richard Daniel	Interim Director of Estates and Facilities – from 27 February 2025
Alex Duffety	Associate Non-executive director – from 1 January 2025
Paul Little	Strategic Director for Service Development – from 24 February 2025
Karen Lough	Director of Operations - Elective Care
Nick Sammons	Director of Estates and Facilities – to 31 December 2024
Alison Stace	Director of Operations - Colchester
Usha Sundaram	Associate non-executive director – to 12 February 2025

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

Register of interests
The Audit and Risk Committee continues its oversight of Trust-wide declarations, gifts and hospitality, receiving a report at each of its scheduled meetings.

The Standards of Business Conduct Policy was revised this year to take account of new guidance issued by NHS England. It was approved by the Audit and Risk Committee in March 2025.

All directors, governors and decision-making staff are asked to declare any interests on the register of interests at the time of their appointment and this is updated as interests arise and on an annual basis. This register is reviewed and maintained by the Trust Secretary and is available for inspection by the public. The register can be accessed on the Trust's website at this link or by contacting the Trust's offices.

Board member interests are included as part of the Board meeting papers, available on the Trust's website. Governors' interests are included within the Council meeting papers.

Meeting legal requirements
The Trust is required by law to operate within the terms of its Provider Licence issued by NHSE. Part of the requirement is that each Trust considers, on an annual basis, its level of compliance with the Licence's provisions. The Board considered and approved the Trust's compliance on 6 June 2024.

The Chair and Chief Executive meet frequently to ensure there is good dialogue on the challenges facing the Trust.

Details of how ESNEFT operates within the local health system as outlined in The Health and Care Act 2022, and the focus on collaborative working, are set out within this report.

The executive leadership team meets on a weekly basis, chaired by the Chief Executive as the Accounting Officer. EMC is the senior operational decision-making forum, and its membership includes all executive directors and divisional management.

In accordance with the Code of Governance for NHS provider trusts, details of the Audit and Risk Committee and its role can be found within this report. The work of the Remuneration Committees can be found within the Remuneration Report.

The Trust's charity reports annually to meet the requirements of the Charity Commission. The report for 2024/25 will be available later this year. Further detail can be found on the charity's website.

Effectiveness and attendance
Where a member is not able to attend a meeting for any reason, this is confirmed with the Chair and Trust Secretary. One member experienced challenges in attending the Board during the autumn. This was raised with the Chair as soon as the conflicting schedules arose, and it was confirmed that attendance at the Board was not going to be possible.

A clear schedule of business is in place and regularly reviewed for both the Board and its committees. Committee terms of reference describe individual committee responsibilities. These are reviewed annually following the review of performance, reporting to the Board in September 2024.

All committees provide a key issues report to the Board regarding the main sources of assurance and any alerts and escalation requiring further action or Board decision.

The Board held 14 formal meetings this year.

Attendance and appointment details for Board members are set out overleaf.

Key:
Board (BoD); Audit and Risk Committee (A&R), Charitable Funds Committee (CFC), Executive Management Committee (EMC), People and Organisational Development Committee (POD), Performance and Finance Committee (PFC), Quality and Patient Safety Committee (QPS), Remuneration and Nomination Committee (RemCo), Council of Governors (CoG)

	BoD	A&R	CFC[2]	EMC	PFC[3]	POD[4]	QPS[5]	Rem Co	CoG[6]
Helen Taylor	14/14							4/5	6/6
Nick Hulme	11/14	6/8	2/7	16/21		3/7		4/5[7]	4/4[8]
Eddie Bloomfield	9/10	3/5	3/3		6/6			2/3	2/2
David Eagles	5/5	2/2	2/3		4/4			1/2	1/2
Mike Gogarty	13/14	2/2	7/7			1/1	9/11	3/5	1/4
Shane Gordon	12/14		6/7	18/21		4/7			1
John Humpston	11/14		6/7		11/12	6/7		5/5	3/4
Hussein Khatib	10/14	1/1			11/12		11/11	4/5	1/4
Dr Tim Leary	7/9		3/5	10/13	3/8	2/4	5/7		
Adrian Marr	13/14	8/8	3/7	18/21	10/12	1		1/1	1
Mike Meers	11/14			15/21	11/12		1		1
Mark Millar	13/14	8/8			11/12			4/5	3/4
Catherine Morgan	10/11		2	12/15	8/9	5/5	6/7		
Kate Read	12/14			16/21	1/12[9]	7/7	4	3/5	2
Karen Sinnott	12/14					5/7	2/11	3/5	0/4
Richard Spencer	10/14	7/8			7/7	6/7	1	3/5	4/4
Dr Angela Tillett			1/1	6/8[10]		2	9/11		
Non voting:									
George Chalkias	11/14	7/8		18/21	11/12	7/7	11/11	4/4	5/6
Richard Daniel	2/2			2/2	1/2		1/1		
Alex Duffety	3/4							0/2	0/1
Paul Little	1/2			2/2[11]	7/12[12]				
Karen Lough	13/14			16/21	11/12		2		
Nick Sammons	6/10			11/17	0/6		3/5		
Alison Stace	11/14			14/21	7/9		4		
Usha Sundaram	7/12	6/7			10/10	1	6/9	3/4	0/4

The shaded area indicates that individuals are not members of that committee.

[2] CFC meets bi-monthly, with business case only meetings on alternate months as required
[3] A deputy will attend for the Director of Finance; when the Chief Nurse and/or Chief Medical Officer is unavailable a Deputy will attend to provide an update on quality and safety issues impacting performance
[4] Membership includes three executives including the Chief Executive or their deputy; the Deputy Director of Finance is a regular attendee representing the Director of Finance
[5] Directors of Operations attend on rotation
[6] Executive Directors are welcome to join Council meetings but are not expected to attend
[7] Acting Chief Executive Adrian Marr in attendance for one meeting
[8] Executive and non-executive directors generally do not attend meetings held in private except for the Chair and the Director of Governance
[9] Deputy in attendance
[10] Attendance in the role of Chief Medical Officer for part year; attends EMC as Deputy Chief Medical Officer
[11] Attendance in new role, having joined the Board as an executive director attendee
[12] Presentation of community report shared with North East Essex Community Services

Board development
This takes place in workshops and seminars to support the Board in undertaking its statutory role.

During the year, the Board held the following sessions:

- The role of the Charity Trustee
- Cyber security
- Primary care strategy
- Artificial intelligence and genomics
- Business planning
- Counter fraud and bribery prevention.

About the Board

The membership of our Board, and our meeting papers, can be found on our website:

Helen Taylor, Chair

Helen joined the Board of Ipswich Hospital in April 2016 and was then appointed to the Board of ESNEFT in 2018. She became Chair of the Trust in June 2019; reappointed from 1 January 2023
Term of office: To 31 March 2025

Chair of Board of Directors and Council of Governors; member of Remuneration and Nomination Committee.

Helen's career in health and social care spans more than 40 years and has taken her from ward to board. After an early clinical career as a nurse, midwife and health visitor, she moved into partnership working within local government. The common theme in all subsequent roles was seeking greater integration of services in the health and care system. Helen has worked at regional and national level including a lead policy role with the Audit Commission and was the statutory director of Adult Social Services in a London borough and a large shire county. The latter part of Helen's working life has been a portfolio of roles including chairing a safeguarding adults board and trustee and executive roles with voluntary sector organisations in Suffolk.

Helen holds a BA in Health Policy and a Masters in Business Administration.

Nick Hulme, Chief Executive

Trust Accounting Officer. Responsible for corporate strategy, external relations, transformation plan, regulation and compliance, leadership.

Nick has worked in the NHS and social care for more than 35 years. He was appointed Chief Executive of Ipswich Hospital in January 2013 and became Chief Executive of Colchester Hospital in May 2016 prior to the merger to form ESNEFT in 2018.

Nick's first management role was in sexual health services before being appointed to senior leadership roles in operational and general management across large and complex trusts.

Non-Executive Directors

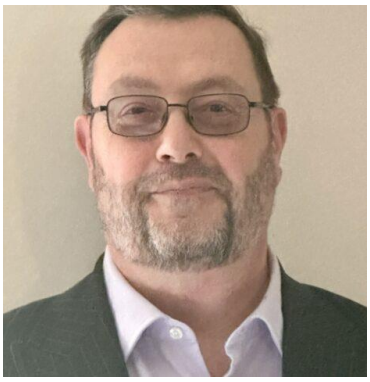
Eddie Bloomfield, Non-Executive Director

Appointed: 1 November 2018; reappointed 1 November 2021
Term of office: To 31 October 2024

Chair of Performance and Finance Committee to August 2024; member of Charitable Funds Committee, Audit and Risk Committee and Remuneration and Nomination Committee.

Eddie held four chief executive roles at the Ministry of Justice, which included head of the Court Funds Office and head of the Office of the accountant general and as HM chief inspector of Court Administration for England and Wales. He is involved with several charities in and around Colchester in trustee and other voluntary positions, and brings extensive experience in political, financial management and change management. He was previously a non-executive director at Colchester Primary Care Trust.

David Eagles, Non-Executive Director



Appointed: 1 December 2024
Term of office: To 30 November 2027

Member of the Audit and Risk Committee, Performance and Finance Committee, Charitable Funds Committee, and the Remuneration and Nomination Committee.

David is a retired external audit Partner, focusing on the public sector, with over 30 years of specialist experience covering the NHS, and local and central government. He led audits of several acute and Mental Health Trusts in the East of England and London, as well as local government audits in Essex, Suffolk and London. At a national level, he was also his firm's lead with various regulatory bodies, including the National Audit Office and NHS England, and previously with the Audit Commission, NHS Improvement and the Trust Development Authority. David is also a past Trustee of Suffolk Family Carers.

Mike Gogarty, Non-Executive Director

Appointed: 1 November 2021
Term of office: Reappointed to 31 October 2027

Chairs the Charitable Funds Committee, member of the Quality and Patient Safety Committee and Remuneration and Nomination Committee.

Lead role: Doctors' disciplinary-Maintaining High Professional Standards (MHPS).

Mike lives in Suffolk and before retirement spent much of his working life in director of public health roles in Essex. He started his career as a GP in Clacton and lived in Tendring for more than 30 years.

John Humpston, Non-Executive Director

Appointed: 1 November 2021
Term of office: Reappointed to 31 October 2027.

Chair of Remuneration and Nomination Committee and People and Organisational Development Committee and a member of the Performance and Finance Committee and Charitable Funds Committee.

John began his career in the NHS as a human resources director before going on to work at board level in four national charities and professional membership organisations – Citizen's Advice, Royal College of Nursing, Crisis and Emmaus. He has held a variety of non-executive board roles in the public, health, community and voluntary sectors. John is currently a non-executive director of Emmaus Cambridge. He is also the past regional director and chair of East of England Samaritans and continues to work with the Samaritans as a listening volunteer.

Hussein Khatib, Non-Executive Director

Appointed: 5 April 2019; reappointed to 4 April 2022
Term of office: Reappointed for 12 months to 4 April 2026

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

Lead roles: Maternity Board safety champion; doctors' disciplinary-MHPS; equality, diversity and inclusion.

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

Mark Millar, Non-Executive Director

Appointed: 1 January 2021; reappointed 1 January 2024
Term of office: To 31 December 2026

Deputy Chair of Board of Directors, Chair of Audit and Risk Committee; member of Performance and Finance Committee and Remuneration and Nomination Committee.

Lead role: Security management including counter fraud.

Mark has a long and distinguished career in the NHS as a chief executive and director of resources, having held several roles. Mark served as a non-executive director at Royal Papworth NHS Trust for seven years. He was previously elected president of the Association of Chartered Certified Accountants.

Karen Sinnott, Non-Executive Director

Appointed: Associate non-executive director 17 April to 30 November 2023. Non-Executive Director 1 December 2023
Term of office: To 30 November 2026.

Karen is a member of the People and Organisational Development Committee, the Quality and Patient Safety Committee and the Remuneration and Nomination Committee and took the lead non-executive role as Health and Wellbeing Guardian in September.
Karen is an experienced executive. She has worked in human resources for 25 years, both nationally and internationally. She brings board experience and a significant track record of leading transformational change. Her experience is in the highly-regulated financial services industry. Karen is People Director at Santander, where she is a member of the senior leadership team, participates in several steering committees and provides strategic leadership in continuous improvement and digital automation, transforming people processes through experiences that deliver long term value.

Karen lives in Suffolk with her husband and daughter. She is passionate about healthcare and addressing health inequalities. She wants to use her business skills to help her local NHS trust improve health services for the community

Richard Spencer, Non-Executive Director, Senior Independent Director

Appointed: 1 November 2018; reappointed 1 November 2021
Term of office: Extended for 12 months to 31 October 2025

Member of the Performance and Finance Committee (Chair for seven months). Member of the Audit and Risk Committee, People and Organisational Development Committee, and Remuneration and Nomination Committee.

Lead roles: Freedom to Speak Up to March 2025; Health and Wellbeing Guardian to August 2024.

Richard is a former director of culture and policy and director of corporate social responsibility at BT and worked as the company's head of strategy and partnerships for mobile telephony. Since taking early retirement, he served on the national Communications Consumer Panel from 2018 to 2024. Richard has also been a trustee of two charities supporting the homeless and those experiencing crisis based in Colchester.

Usha Sundaram, Associate Non-Executive Director

Appointed: 17 April 2023
Term of office: To 12 February 2025

Non-voting member of Quality and Patient Safety Committee, Audit and Risk Committee and Remuneration and Nomination Committee

Usha is an Associate Professor in consumer and digital marketing at Norwich Business School, which is part of the University of East Anglia. She is Associate Dean for the Social Sciences Faculty. Her portfolio remit is graduate employability and opportunities.
Usha has over 30 years of experience in training and education in the hospitality, tourism, and retail sectors and nearly 10 years of non-executive director experience in charities, social housing, schools, and higher education. She has experience in investment appraisal, service user outcomes and experiences, audit, risk, assurance, and complex digital transformation.

Alex Duffety – Associate Non-Executive Director

Appointed: 1 January 2025
Term of office: 31 December 2026

Alex is the Director of Finance and Operations at the Royal College of Psychiatrists where she leads the teams covering College finance, governance, business development and facilities in the London and devolved nation hubs.

Qualifying as a Chartered Accountant with Deloitte, in Cambridge, and subsequently holding a number of senior finance roles in the private and public sector, prior to working at the Royal College of Psychiatrists, Alex was the COO of a large Multi Academy Trust in the East of England. This included delivering award-winning transformation programmes and support service improvement.

Executive Directors

Tim Leary, Interim Chief Medical Officer

Tim has extensive experience in medical leadership and has joined us on secondment from a senior leadership role at the Norfolk and Norwich University NHS Foundation Trust.

Tim is a consultant anaesthetist.

Chief Nurse

Catherine is a senior nurse leader with more than 30 years' experience in the NHS. She has an established and strong clinical leadership reputation from a significant acute trust career, as well as a regional portfolio at NHS East of England as Chief Nurse. Catherine's successful record of accomplishment throughout the eastern region and London includes time in NHS trusts in Colchester, King's Lynn, Chelmsford and Ipswich, predominantly in nursing leadership roles supporting trusts with clinical improvement. She also specialised for nine years as a consultant nurse in renal medicine. The Queen's New Year's Honours list for 2021 recognised Catherine's services to nursing when she was awarded an OBE.

Shane Gordon, Director of Strategy, Research and Innovation

Dr Gordon is a clinician with over a decade of senior NHS management experience in transformational change, strategic and local commissioning and acute hospital leadership. He is passionate about improving services through innovation, evidence-based practice and the use of information to drive positive change.

Dr Gordon is vice chairman of the East of England Clinical Senate. He was previously clinical chief officer of North East Essex Clinical Commissioning Group, associate medical director of the East of England Strategic Health Authority and is a member of the Royal College of General Practitioners and the Royal College of Surgeons.

Adrian Marr, Director of Finance
Deputy Chief Executive from January 2025

Adrian has worked in the NHS for over 35 years and was appointed to the ESNEFT Board in 2019. He has undertaken finance director roles in provider and commissioning organisations and was previously director of finance for NHSE in the east of England.

Mike Meers, Director of Digital, Logistics and Operations - Ipswich

Mike has worked within local NHS services for more than 28 years managing information technology services and their transformation. During this time, he has led the delivery of major infrastructure, corporate and clinical IT systems from procurement through to implementation. Mike has responsibility for development of the Trust's ICT strategy and supporting ICT programme delivery and support functions including the digitisation of records management.

Prior to taking up the Director of Information Communications and Technology post for the Trust in 2018 he was Chief Information Officer at The Ipswich Hospital NHS Trust and led the integration of ICT services for acute and community services.

Mike has responsibility on the Board as the Senior Information Risk Owner (SIRO). The role was created to provide board-level accountability and greater assurance that information risks are addressed.

Kate Read, Director of People and Organisational Development

Kate is an experienced Director of People with over 25 years' experience working within the NHS. Kate has extensive experience in both HR and education with a proven track record of delivering workforce transformation, cultural change, and organisational development. With extensive knowledge of employment law, workforce planning, staff wellbeing, and equality, diversity and inclusion (EDI), Kate plays a pivotal role in shaping a high-performing, compassionate workforce aligned with the values of the NHS.

As a member of the Trust Board, Kate provides expert guidance on workforce strategy, ensuring the Trust recruits, retains, and develops an inclusive workforce. Kate also works closely with clinical and operational leaders to ensure that staffing structures support safe, effective care.

With a commitment to staff engagement and continuous improvement, Kate champions the NHS People Promise and leads on initiatives that promote psychological safety, leadership development, and organisational learning.

Non-voting members of the Board

George Chalkias, Director of Governance

George joined the Trust in May 2023. He was previously the Trust Secretary at the West London NHS Trust where he led the Trust's corporate governance function for four years.

Prior to this, George worked as Corporate Governance Manager at The Royal Marsden NHS Foundation Trust and has also worked in public policy for elected representatives in Westminster.

Richard Daniel, Interim Director of Estates and Facilities

Richard joined the Trust in February 2025 to lead the service prior to a permanent appointment being made. Richard has extensive experience working across the NHS.

Alison Stace, Director of Operations and North East Essex Community Services

Alison has been the Director of Operations since 2017 and has over 35 years of NHS service beginning her career as a nurse. She has extensive expertise and experience in medicine and emergency care, cancer care, community care and transformational change. She has worked in both clinical and operational senior leadership roles and is currently the SRO for System Resilience and the UEC Lead as part of the North East Essex Health and Wellbeing Alliance.

Paul Little, Strategic Director for Service Development – from February 2025

Paul has an extensive background in adult community health and social care services and has been the Director for Integrated Health and Care in a joint role with ESNEFT and Suffolk County Council since 2019. In this role Paul developed positive working relationships with all our system partners and will be building on that experience to develop new models of care to serve and support people in their communities.

Karen Lough, Director of Operations - Elective Care

Karen is a highly experienced director of operations and has worked in the NHS for over 20 years.

Karen began her career in the NHS at Ipswich Hospital. She has worked in a large teaching hospital and in commissioning across the East of England. Karen's focus is on the provision of elective, diagnostic and cancer services across the Trust.

Board changes during the year

Trust Chair Helen Taylor left the Trust on 31 March 2025 after nine years supporting ESNEFT and Ipswich Hospital NHS Trust. Helen spent three years as a non-executive director and was the Chair for six years. The Council of Governors sought to recruit a replacement in late 2024 but despite a rigorous and wide-ranging process an appointment was not made. Mark Millar, Deputy Chair, was confirmed as the Interim Chair from 1 April 2025 for a period of six to 12 months.

Angela Tillett has taken the decision to step down from the role of Chief Medical Officer. Angela continues as part of the executive leadership team in the role of Deputy Chief Medical Officer, Colchester.

Dr Tim Leary joined the Trust as Interim Chief Medical Officer in August 2024. Recruitment to the permanent role is due to conclude early in 2025/26.

Nick Sammons held the role of Director of Estates and Facilities until 31 December 2024. Richard Daniel joined the Trust as Interim Director of Estates and Facilities on 27 February 2025. Recruitment to the permanent role is underway.

Paul Little joined the Board as an executive director attendee from 24 February 2025. Previously a joint appointment with Suffolk County Council, and already a member of the Executive Leadership Team, Paul is seconded to ESNEFT in the role of Strategic Director for Service Development.

The Non-Executive Director appointments and reappointments made by the Council of Governors this year can be found within the Remuneration Report.

NHS England's well led framework

ESNEFT continues to have in place:

- An established and embedded leadership structure at both Board and divisional level
- A five year clinical strategy, refreshed in 2023/24, following extensive internal and external consultation; and a range of enabling strategies to drive the programme - quality, inequalities, digital, cyber security, estates, green plan and people
- The ESNEFT values (OAK: optimistic, appreciative and kind) on which we continue to develop the ESNEFT way, alongside our philosophy of 'time matters'
- Divisional governance and our accountability framework aligned to the well-led framework. There is a transparent view of performance throughout the organisation which is reflective of quality, operational performance and financial management
- A risk management culture which has developed further during the year, with a revised approach to how risk appetite operates
- An Accrediting Care at ESNEFT programme focussed on the fundamentals of care
- A Quality Improvement (QI) faculty supporting continuous improvement and innovation
- A Faculty of Education supporting the ongoing development of our staff and encouraging local people to develop careers in health.

At our last Care Quality Commission (CQC) inspection in 2019 the well-led domain was rated as good, noting that:

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

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

- Staff felt respected and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

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

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

Details of the inspections received this year, and the oversight on delivery of actions plans by the Board's Quality and Patient Safety Committee can be found within the Annual Governance Statement.

NHSE requires all NHS foundation trusts to complete a developmental well-led review every three to five years, which must be carried out by an independent third-party organisation. A review was carried out by Deloitte LLP and reported to the Board in December 2022. During 2025/26, the Trust will undertake the planning for a further review to take place in early 2026/27.

The Audit and Risk Committee

The Audit and Risk Committee has been chaired by Mark Millar, non-executive director, throughout 2024/25 prior to stepping down from this role on 31 March 2025.

Membership of the Committee is limited to three independent non-executive directors not including the Trust Chair. Meetings are attended by the Director of Finance, Director of Governance, Trust Secretary, the Head of Internal Audit, a Local Counter Fraud specialist and a representative of the External Auditors.

The committee met on eight occasions during the year and is formed to:

- Discharge the responsibilities of an Audit Committee under Paragraph 23(8), Schedule 7, *National Health Service Act 2006*
- Review the effectiveness and assurance available regarding the internal control systems in place for the Trust
- Support the Board and the Accounting Officer in the appointment of an internal audit service

- Support the Council of Governors in the appointment of an external auditor
- Review, prior to Board consideration, the Annual Report and Accounts for the Trust, together with related audit reports
- Have oversight of the effectiveness of controls in place to prevent fraud, corruption and conflict of interest in decisions
- Have oversight of the risk management systems for the Trust; and support the Board in the management of the BAF.

Attendance can be found here.

Assurance is sought from several areas, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness:

- The work of internal audit
- The work of the local counter fraud specialist
- The work of External audit
- Through the representations given by directors and managers as appropriate; and
- The findings of other significant assurance functions, both internal and external to the Trust, i.e. reviews by regulators or other professional bodies.

An internal audit function is outsourced from an external third party provider, RSM UK Risk Assurance Services LLP. A detailed description of the work of internal audit and the significant issues considered by the committee in relation to the financial statements, operations and compliance are included in the Annual Governance Statement.

The external auditors for the Trust are EY, appointed for a period of three years, with year one being 2023/24. This included an option to extend for two years. The effectiveness of the external audit process is assessed by the Audit and Risk Committee through direct receipt of reports from the external auditors to the Committee, through a formal management report on their work and an annual review. A meeting takes place at the end of the annual audit to reflect on the work undertaken, involving the Committee Chair, Chief Executive, Director of Finance and external audit representatives. The outcome is presented to the committee.

Developing services for our patients

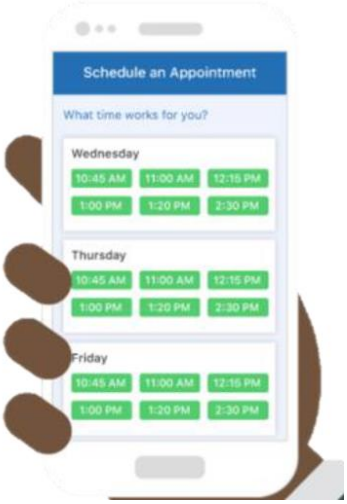
Epic Electronic Patient Record

At the end of March 2024, we signed a contract of £133m for a new electronic patient record system called Epic.

The creation of a new, single system will help us to better manage patient information across our sites, bringing significant benefits to patients and staff alike.

Currently we use more than 120 different systems across our sites, as well as paper notes, to manage patient information, but this can cause a number of challenges, including:

- patients having to repeat information about their situation or condition
- duplication of data across different systems and even within single systems
- issues accessing records quickly



Moving to one single system will help us to update and access information more quickly and easily and will also offer new ways of working that will help us improve patient care, such as e-prescribing, decision support tools and improved workflows.

The system will also enable patients to have greater control over their health through the MyChart app, where they will be able to access appointments, letters and information about their health. Although this is an electronic system, patients will still be able to access letters and information through the post should they need to. The benefits of using this system include translation if English is not the first language. MyChart supports screen reader and allows the patient to use the normal zoom function and also colour contrast settings.

The system will be delivered by October 2025.

Clinical services integration

Alongside progressing a broad portfolio of service-specific projects clinical services integration has supported, for two pathfinder services neurology and renal services, the amendment of leadership and management arrangements into a single management structure. Previous line management and leadership has been site-specific for some services that do not have a significant non-elective focus. These services have been aligned to one of the existing divisional management teams based on:

- Initially led and managed by the Medicine divisions at either Colchester or Ipswich
- Provided on both sites – including those with potential for development into either ‘hub and spoke’ or ‘consolidated’ delivery models
- Strong clinical and/or operational cases for integration
- Principally elective care focus.

These changes are being delivered – in line with the Trust's Clinical Strategy to:

- standardise care for our population
- reduce variation in the way we provide care through standardising our clinical pathways, guidelines and standard operating procedures
- ensure joint governance of our services across the Trust and across the ICS
- integrate clinical services with system partners building on the local integration and standardisation of ESNEFT services.

Research and Development

Why we do research
Clinical research is vital for providing the evidence needed to deliver high-quality and cost-effective healthcare services, to improve outcomes and services for patients both locally and nationally. Every treatment we provide at ESNEFT is the result of research.

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

How our research performs

We continue to work with many different organisations nationally and internationally so that our patients can access new medicines, devices or treatments as part of clinical studies. As an example, in June we opened our first sponsored National Institute for Health and Care Research (NIHR) portfolio study in collaboration with the University of Essex, the OPEN trial. This study is running to understand if providing online education and self-treatment tools to people with kneecap pain who are waiting for physiotherapy helps reduce pain.

In September we were thrilled to be the first UK Trust to recruit a participant into an international dermatology drug study, offering a potential treatment for vitiligo.

As of the end of March 2025, 9,362 patients, carers, colleagues, and healthy volunteers took part in 129 clinical studies, across 31 clinical units, including 1,004 patients to studies with pharmaceutical industry partners.

During 2024/25 the top three areas of highest research activity by participation were Diabetes, Oncology and Reproductive Health. We continuously exceed recruitment targets for our studies and are often within the top recruiting sites in England. Examples include ASPECT a respiratory study, MajesTEC-9 a commercial haematology study, POETIC-A a cancer study, AMY106 a commercial trial looking at endometriosis, Correct MRD a colorectal cancer study and PIVOTALboost a radiotherapy study.

The ethnic composition of our research participants for 2024/25 is similar to that of the populations served by our Trust.

Where Ethnicity is known	Research Participants ESNEFT 2024/25	Population SNEE
White British/White Irish/White any other	92.22%	94.70%
Mixed/multiple ethnic groups	2.22%	1.70%
Black/Black British/ Caribbean/African	1.69%	1.00%
Asian/Asian British/Indian/Asian any other	2.59%	2.10%
Any other ethnic group	1.28%	0.50%

Commercial studies
Often our commercial partners come back to ESNEFT due to our set-up process, high data quality and delivery services, excellence in recruitment, retention and patient satisfaction. Our diabetes team is one of the highest commercial recruiters in the region, running trials including a range of research from diabetes to cardiovascular outcome trials and metabolic medicine (obesity, NAFLD & Cirrhosis). It continues to be a favoured site by many industry partners and will this year extend its work to our own academic research involving small fibre neuropathy.

Boosting our capacity for research
In August we launched our STARs registry to enable us to better understand neurodevelopmental conditions in our local area. We will collect information on local children's development and any related symptoms they may have alongside their diagnosis. More information is in our video STAR's Registry

The data collected will help us:

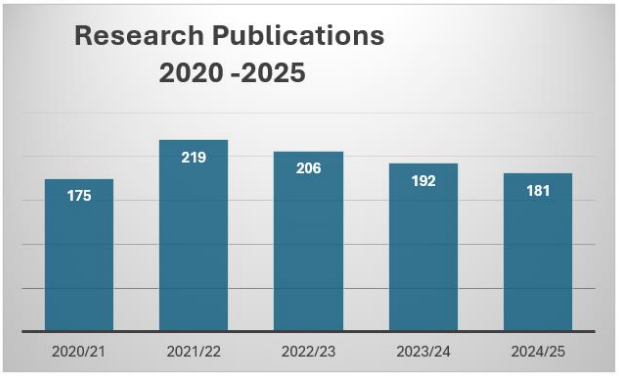
- understand children with neurodevelopmental conditions needs
- design research studies to meet these needs
- identify studies that people are potentially eligible for, based on their symptoms or neurodevelopment condition generally.

More information can be found in our video STAR's Registry.

Our Synapse Centre for Neurodevelopment continues to grow with the addition of a research genetic counsellor. More detail on the work and why we do research at the centre can be found in our video The Synapse Centre

Continually embedding research for all of our patients
As a research active organisation, we strive to embed research as an expectation. In January we achieved this within our maternity unit at Ipswich Hospital by opening the INGR1D2 study. This screening study is offered to all babies born and aims to identify newborns who have an increased genetic risk of type 1 diabetes.

Our team
Over the past 12 months, our employees have demonstrated the vibrancy and innovative practice of a research active organisation by producing a total of 181 conference abstracts and publications in high quality academic journals.



Our dedicated 149 researchers – 122 clinicians and 27 AHPs, nurses, practitioners and midwives acting as principal investigators, lead on research. We currently have nine staff on the National Institute for Health and Care Research (NIHR) associate principal investigators scheme, training to lead clinical studies and one NIHR greenshoot award to support new entry principal investigators. This is in line with our strategy to expand our range and reach across the Trust, to embed research into core business

In January we were extremely grateful to our Colchester and Ipswich Hospitals Charity in supporting the launch of our first research grant for locally collaborated research. This bought a fantastic response of 30 applications. We awarded £200,000 to enable our own researchers the opportunity to develop and deliver their own research ideas.

As part of our strategy, we continue to strengthen careers for our staff.

Our clinical academic workforce has again increased this year, with several successful NIHR Career fellowships being obtained for the following programmes:

- NIHR pre-clinical academic fellowship
- NIHR pre-doctoral bridge fellowship
- NIHR post-doctoral bridge fellowship.

Likewise, our first NIHR ARC Fellowship was awarded to one of clinical research practitioners.

Edyta Klata has been awarded our first NIHR ARC Fellowship

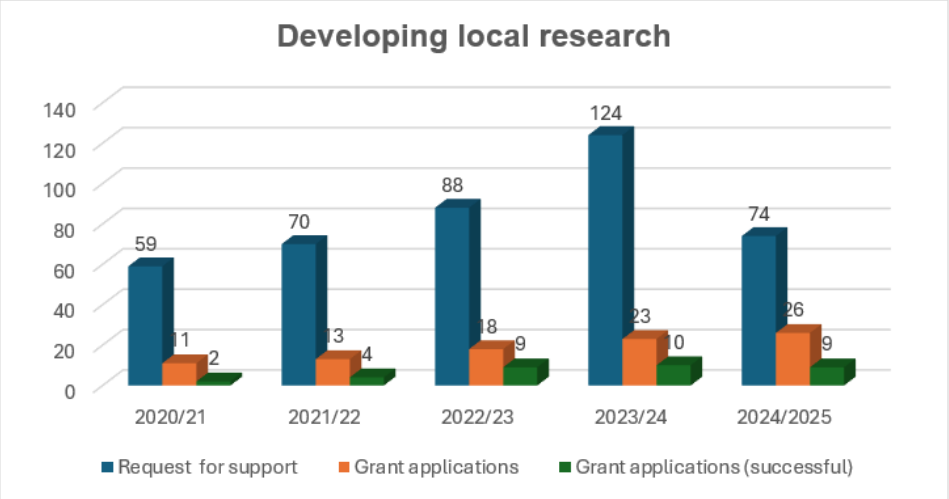
Locally we have set up a NMAHP Research Champions network where people with an interest in developing as clinical academics can join

Research nurse Kate Barber has been awarded the title of a Queen's Nurse

One of her patients and their relatives nominated Kate for the privileged position, which doesn't mean she's now a nurse to royalty, but that she's been awarded the special title because of exceptional service to her role, demonstrating her commitment to patient care in the community.

Kate, whose role at ESNEFT is Motor Neurone Disease (MND) coordinator and specialist research nurse, said she's delighted to have been awarded the position.

Locally developing research
Our researchers have the support and the infrastructure to help them enable patients to benefit from participating in research. We have supported 74 requests for support from our locally developed team and have received nine external grant awards.



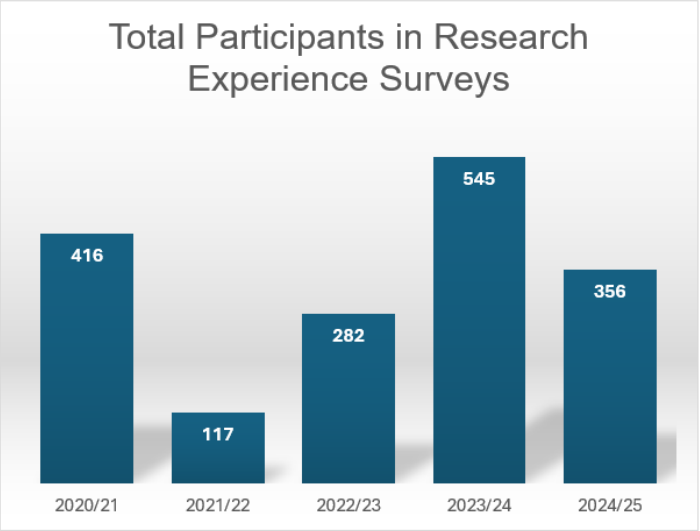
Requests for support for locally developed research and successful grant outcomes by year

Putting people first – embedding public involvement

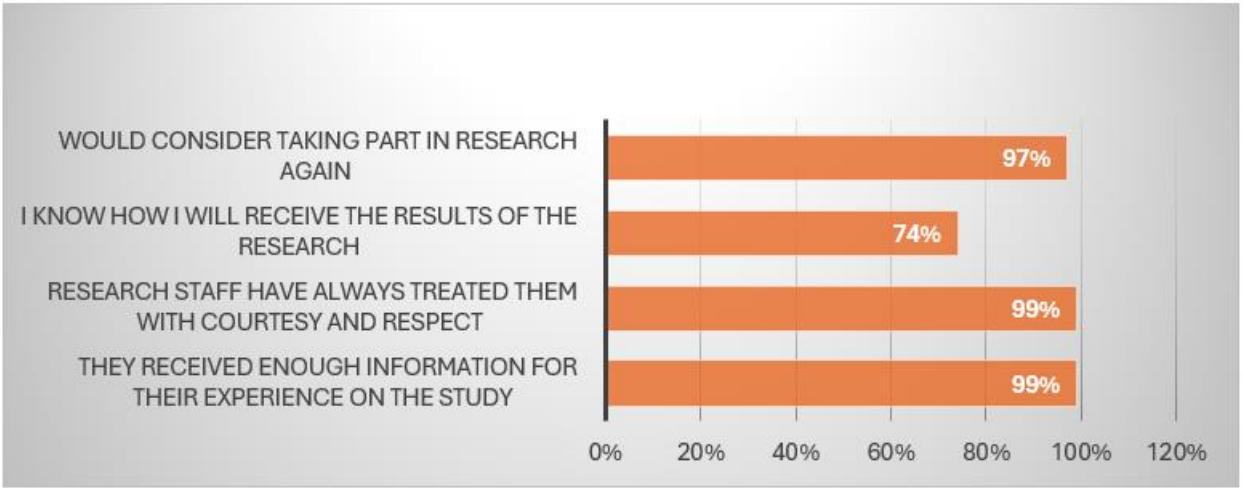
In November we became the first NHS Trust to sign up to a shared commitment to public involvement with the Health Research Authority. Our joint commitment is to improve the extent and quality of public involvement across the sector, so that it is consistently excellent.

We strive for inclusion for our patients and community. We strongly believe that patients should provide feedback on our research, so that research is developed with them. This is of huge benefit, and we actively encourage participation in designing and running studies. This year we had an additional three new patient and public involvement groups with 26 people attending to help shape our studies. Examples include stroke, rheumatology and musculoskeletal

Participation in our research experience survey this year, gave favourable results. We continually ask research participants about their experience.



What our participants said……



Research participants also provided written comments.

What was positive about your research experience

The research team were really friendly and gave me really helpful advice on my own condition which has benefitted me greatly, I was made to feel special for taking part & everyone was so grateful.

I think anything that helps N.H.S to be better is a good thing.

Being part of a trial that could help me and others in the future.

What would have made your research experience better?

From a personal perspective I would like to understand more of what the research is working to achieve and what the outcome was

Being kept up to date with the study's progress and results

Knowing that it helped in the future

To improve the feedback to participants, when setting up our studies we now work with the sponsors of the study to ensure that we have details of how the participants are going to be kept informed and ensure that they have access to the results at the end of the study.

The responses also provide data on ethnic group, summarised below. The ethnic groups are based on a sample of 341 (i.e. 96% of the 2024/5 research participants) the ethnic composition of research participants is similar to that of the populations served by the Trust.

Q16. Ethnic group		Record count
1	White/English/Welsh/Scottish/Northern Irish/British	323
2	White/Any other White background	7
3	White/Irish	3
4	Mixed/Multiple ethnic groups/White and Asian	2
5	Black/African/Caribbean/Black British/African	2
6	Mixed/Multiple ethnic groups/Any other mixed/Multiple ethnic backgrounds	2
7	Asian/Asian British/Indian	1
8	White/Gypsy or Irish Traveller	1

Source: Regional Research Delivery Network East of England

Expanding our portfolio

In November we opened one of the largest elective orthopaedic centres in Europe at our Colchester site - ESEOC. We began embedding research straightaway and in January appointed a research physiotherapist who will be supported by our generic research team and our joint professor of AHPs with Anglian Ruskin University. This will enable us to expand our musculoskeletal research service and to offer many more opportunities for our patients to benefit from taking part in research.

We aim to maintain and further grow the breadth and depth of our research capability and capacity. We will continue to support and develop researchers and increase the availability of research opportunities for our ESNEFT community and open opportunities for our patients living in distant areas to participate in research by taking the research to them.

We have made available seven research studies at our Harwich and Clacton sites. Being able to take part locally has removed the geographical barrier and being part of a research study at Clacton's dialysis unit looking into treatment options has helped patients feel more positive. It also gives researchers more confidence that the findings are representative of the population we serve.

Gloria Herbert

Gloria lives in Clacton and previously worked as a cultural awareness team leader for CVS Tendring before becoming poorly and feeling constantly tired. She was diagnosed with chronic kidney disease in November 2022 and now has dialysis three times a week.

The 62-year-old said: "I have no choice – it's dialysis or die and emotionally it's very difficult at times to feel positive, but there's so little out there about kidney disease I'm keen to do everything I can to raise awareness – including be part of a research study." Gloria joined the RESOLVE study looking at if there's an optimum level of salt that's better for patients' hearts during their treatment.

The future
We are tremendously proud of our research this year. As we look forward, the UK government has made it clear that they want the UK to be a world leader in clinical trials and recognises the importance of life sciences to the health of the nation and growth of our economy. The message is clear, we all need to do more to help speed up the approval process and make it easier to set up research in the UK.

Our Research and Development unit is fully behind this vision. Delivering the implementation of the research module of our new EpicEPR will be transformative in helping speed up research delivery and unleash the true potential of clinical research right across our Trust, for the benefit of our patients and teams.

Supporting innovation

Robotics

ESNEFT is the fastest growing Trust for robotic surgery in the UK. Colchester Hospital is the first in the UK, Ireland, and Europe to offer a fully robotic service for all patients undergoing elective colorectal procedures following successful completion of training for all six colorectal surgeons last year.

ESNEFT continues to excel in robotic surgery, having now treated more than 2,500 major complex procedures robotically across colorectal, urology and gynaecology. We have gained international recognition for our programme with surgeons visiting from across the UK and Europe to see what excellence looks like.

Patients have better outcomes through robotic surgery as it is more precise and therefore less invasive meaning patients heal and recover more quickly. It is also much better for surgeons too as they are able to sit separately at a console making it less stressful on their own body and hopefully extending their surgical career.

More procedures are now being carried out robotically, including hernias and gallbladders, and we aim to continue to expand our robotic programme to new areas in the future to benefit even more patients.

The gynaecology team has become one of the few in the country to carry out six successful hysterectomies in just one day. The procedures were such a success that four of the patients were well enough to return home the same day. The high intensity team event took place to improve waiting times for patients at Colchester Hospital.

We are able to offer unique training and development opportunities in robotic surgery and have now supported more than 50 trainees across surgical specialities through our own unique and well-structured training programme at the Iceni Centre, including international masterclasses.

In 2024, Colchester Hospital was selected to become one of two host centres by The Association of Coloproctology of Great Britain and Ireland to offer robotic surgery fellowships. To be the first site in England to be awarded this funded fellowship is an endorsement from the national body of their confidence in the quality of ESNEFT's robotics journey and the value we place in training and education. The fellows have had an excellent experience to date.

In partnership with Anglia Ruskin University through The Institute of Excellence in Robotic Surgery (TIERS) collaboration, September 2024 saw the launch of a brand-new MSc course in robotic surgery.

Innovation Fellowships Programme
In October 2024, eight ESNEFT staff members commenced the second cohort of the Programme, launched in 2023 and co-delivered with the University of Suffolk. It provides staff with protected time away from their day job to commit to learning the skills to drive change and innovation within the Trust.

This programme provides class-based training to develop the entrepreneurial mind-set, confidence and skills of participating Innovation Fellows, with the training covering:

- methods to innovate and identify new ways of working
- the basics of intellectual property
- market analysis
- business planning
- pitching of their innovative ideas
- stakeholder holder engagement and implementation.

Our innovation team works alongside the Innovation Fellows to help provide them the structure and support to implement their ideas within ESNEFT.

The Programme is running for three years, and each year there will be a new cohort of up to 10 Fellows undertaking the nine-month Programme.

The first cohort delivered in 2023/24 was successful with a number of ideas still being pursued and several participants gaining promotion within the Trust. The areas being considered by the fellows include:

- Rapid response for paediatric respiratory cases
- Sustainable energy saving ideas
- Digital blood tests
- Patient deconditioning
- Weight management referral processes.

Artificial Intelligence (AI)
The AI council is one year old and now has a breadth of specialities contributing. It has developed governance around the use of AI in the Trust and strategic direction encompassing the impending start of Epic.

It has overseen exciting and innovative work with local universities with the knowledge transfer partnerships, bringing the possibility of homegrown AI closer. It has helped in major commercial research with the LungImpact trial. It has been a source of expert advice and post deployment surveillance for existing and new AI endeavours, such as Co-pilot and clinical products in radiotherapy, radiology and cardiology.

AI in medicine is a rapidly evolving topic and the council's plan is to evolve with it, to provide safe reliable products to the Trust which have demonstrable advantages and educate our patients and staff on what is being used.

- **Case Study: Boneview**

Since June 2024 we have been working on a 12-month evaluation of Boneview. Boneview is a product from Gleamer. It is used in over 2,500 locations in 45 countries and reviews over 40 million images every year.

Boneview supports the reading of x-rays, detecting fractures, effusions, dislocations and lesion on trauma X-rays of the spine pelvis and appendicular skeleton. Boneview integrates with the PACs system. Providing a second read of x-rays to the level of a junior radiologist.

It supports non-specialist clinicians to interpret x-rays. The AI read takes seconds, identifies a possible abnormality with a box to make interpretation easier.

All x-rays are reread by a radiologist, as per standard of care, who will validate the Boneview opinion.

Early indications of using the tool show that:

- There has been a reduction in call backs to the fracture clinic reducing patient inconvenience and pain
- This earlier diagnosis can improve outcome for patients
- Patients are happier with the service *and* money is being saved
- Concerns regarding possible increases in requests for CT scans and fracture clinic attendances have been satisfied.

- **Case Study: Brainomix**

We have been working on an evaluation of Brainomix an AI stroke platform since 2021. The evaluation finishes in November 2025 having been designed in the UK in conjunction with Oxford University and is part of a national report with publication of results. It will also be evaluated locally.

Speed is particularly important as the stroke clinical pathway is highly time sensitive. For every 15 minutes of delayed treatment, stroke survivors may lose a month of healthy life.

The software analyses images of the brain and blood vessels within minutes. It flags findings to clinicians to help rapid treatment decisions. The technology also allows ESNEFT's stroke teams to securely and instantaneously share these scans, 24/7, with colleagues at specialist centres to gain a neuro interventional radiologist opinion.

The platform hopes to improve the number of patients who receive a minimally invasive procedure called Thrombectomy.

Colchester Hospital stroke lead Dr Ramachandran Sivakumar
and advanced nurse practitioner Rebecca Smith

In a large real world study Brainomix resulted in a 50% increase in patients receiving lifesaving treatment (Thrombectomy) and a 49 minute time saving reduction in DIDO (Door In Door Out) times. Reducing the decision time by all members of the team, results in more patients receiving the right treatment.

- **Case Study: NeuHealth**

The Trust has been working with NeuHealth since November 2023 on an evaluation that ends in December 2025. Neuhealth is an AI platform for Parkinson's patients designed in the UK as part of a spin off from Oxford University.

The platform allows patients' smartphones to turn into medical devices, enabling patients to track cognitive, motor, and behavioural functions. Through tailored exercises, phones capture data on gait, balance, tremors, reaction time, and voice. The test results are seen by clinicians and judgements can be made about medication changes and how frequently the patient should be seen.

This added data allows quicker OP appointments and flags patients with worsening symptoms earlier, hopefully leading to more agile, patient initiated follow up. This maximises the benefit of clinics, seeing those patients who are struggling quicker and not wasting patients' time on follow ups when they are stable. It enables the patient to better understand and actively manage their Parkinson's.

In surveys carried out by Neuhealth, all the clinicians surveyed said:

- they knew more about the patient
- 53% of all clinic appointments resulted in a change to a patient medication
- 60% of patients saw an improvement in bone health due to the fall prediction score triggering a change in medication
- 9% of patients saw an increase in their empowerment over their Parkinson's.

Genomics
The Genomics Working Group was established in September 2024. The group was set up to develop a strategy for genomics and to identify areas of opportunity. Since its inception the group has identified opportunities for improvements with test submissions and genetic pathway variations that were resulting in extended test turnaround times.

Subsequent work has led to:

- an improvement in turnaround times for most tests
- more tests being sent to the regional genomics hub which has in turn led to financial savings
- the identifying and sharing of both issues to be resolved and best practice between departments.

Future work will focus on:

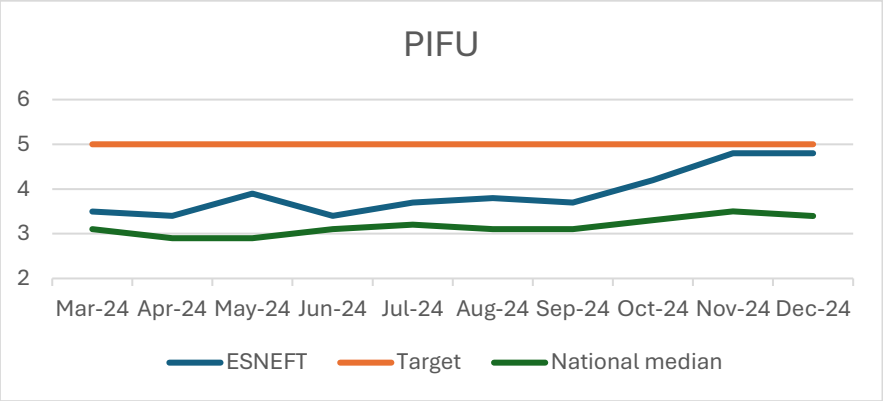
- prioritising key areas to drive measurable improvements in clinical outcomes
- building a structured framework for the implementation of new genomics testing
- further developing and educating the genomics workforce to enhance awareness and expertise.

Transformation
In 2024/25, the transformation team continued to deliver the objectives, as set out in the comprehensive two year medium term plans. These were developed with the transformation team and clinical divisions at the beginning of 2023/24 covering elective, cancer and diagnostics, urgent and emergency and community care. Plans included setting out a two-year vision, strategic objectives, projects, work streams and success measures. The team have also supported delivery of the Clinical Services Integration Programme, all linked to the clinical strategy, divisional business plans and national planning priorities.

A summary of some of the key achievements is set out below:

- **Elective Care Programme** – the key focus this year has been the national GIRFT Further, Faster programme. Upon completion of a data review on the various work streams and completion of checklists to assess alignment to the national workbooks, work commenced with the relevant specialties to increase compliance and improve associated metrics.

- **Outpatients - Patient Initiated Follow Up (PIFU)** – further work across specialties has enabled continuous increases to the number of patients being offered PIFU rather than booked for a follow up appointment. Successful projects were delivered in specialties including diabetic medicine, endocrinology, ophthalmology, respiratory, rheumatology and neurology. These improvements meant that 35,038 patients were offered a PIFU option between April and December 2024, compared with 26,379 from April to December 2023. This work has supported reductions in follow up waiting list backlogs and offered conversion to enable additional new (first) outpatient appointments.



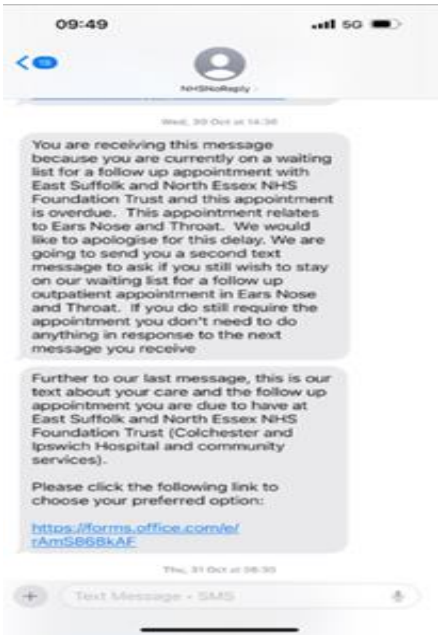
- **Outpatients Pre-appointment –** successes this year include the improvement of multiple pre-appointment pathways, the re-launch of Specialist Advice, *(Advice and Guidance),* in gastroenterology, the introduction interface multi-disciplinary teams in trauma and orthopaedics Colchester and joint primary/secondary care clinics, gastroenterology, chronic kidney disease, dietetics and dermatology. In addition, multiple referral forms have been reviewed, updated and combined in gynaecology, respiratory, neurology, cardiology and dermatology. By enhancing pre-referral guidance, quality of referrals and utilisation of Specialist Advice, this enables patients to be seen by the right clinician, in the right place, first time and creates capacity for secondary care clinicians to provide specialist input.

Further Faster KPI	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Specialist Advice Utilisation Rate	7.3%	7.8%	7.5%	18.7%	19.4%	19.9%	22.0%	24.1%	22.3%
Target	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
Variance to target	▼ -8.7%	▼ -8.2%	▼ -8.5%	▲ 2.7%	▲ 3.4%	▲ 3.9%	▲ 6.0%	▲ 8.1%	▲ 6.3%

- **Outpatients Text Campaigns –** we have introduced an automated text messaging service to patients waiting on our new and follow up appointment lists, to ascertain whether they still require the appointment.

  Over a three month period, for new patients waiting over 40 weeks, 475 have confirmed they no longer require an appointment and for patients waiting a follow up appointment, over 1,280 have been discharged or moved onto a PIFU option.

  The implementation of text campaigns saves patients unnecessary hospital visits and reduces Do Not Attends, enabling better utilisation of current capacity for patient appointments.



- **Theatres, Green Surgical Hub** - the Hub was opened on 29 July 2024. This was the culmination of a construction project alongside a workforce plan, which will enable ESNEFT to deliver an additional 4,200 procedures over the year. High Volume, Low Complexity procedures are the focus for activity, with same-day discharge as the default position. This is expected to significantly reduce the overall number of patients who are waiting over 52 weeks for their surgery.

The Green Surgical Hub, which includes three specialist theatres, a recovery area and a post-operative care unit, is utilised for a wide variety of procedures, including general surgery, ENT, oral surgery and urology, many of which will be carried out as laparoscopic surgery.

From initial construction….

……to completion

Upon establishing the Green Surgical Hub, a large work stream jointly held with operational and clinical colleagues has commenced working towards achieving accreditation status. We have been enrolled onto the June 2025 cohort of trusts, in which after completing a four month process including site visits and evaluations, we are confident in meeting our objective of attaining accreditation status.

- **Urgent and Emergency Care Programme** - after six years of designing, building and planning implementation, the Urgent Emergency Care Centre (UECC) opened on 7 September 2024. The new UECC brings together an Urgent Treatment Centre and the ED into one integrated service. It is now in a prime location within the hospital, within easy reach of all acute assessment units and offers significant additional physical space to manage sustainable demand and enable improved service models of care. An additional CT scanner is within the UECC footprint, providing quick access to urgent scans and improved patient experience.

Since opening, extensive work has been carried out between clinical, operational and transformation teams to refine the model for Urgent and Emergency care at Ipswich Hospital.

Through sharing good practice across sites and learning from both the successful Front Door Assessment Team and Ambulatory Emergency Care Unit models at Colchester, the models have been refined and implemented at Ipswich UECC. Since implementing the AECU model at Ipswich in January, on average around 40 patients a day have been treated within the unit.

In adopting an 'ESNEFT way', implementation of these models has resulted in pressures being alleviated in the main waiting room, patients being seen and treated in the most appropriate clinical setting, by the right clinician, first time.

- **Surgical Assessment Unit (SAU) at Ipswich** - following a request from surgical doctors to support them with quality improvement opportunities in their area, a full review of processes was undertaken to establish where improvements could support patient safety and staff wellbeing. As a result, several changes were made, including:- successful implementation of an electronic patient tracking system, i.e. "Watchpoint", which will also help in transitioning process to Epic, process and pathway changes to reduce overcrowding, reduce numbers of returning patients, purpose a dedicated clinical handover office and aligned Trust emergency care pro-forma, saving clinician time and avoiding patient repetition.

- **Unscheduled Care Coordination Hub** – since establishing the hub as a business as usual service in 2023/24, work has been undertaken with the wider system. The objective of sustaining an increase in operational hours to 12 hours a day, seven days a week has been met. Referral pathways have been introduced for Acute Medical Same Day Emergency Care services at both ESNEFT sites by streamlining the pathway. This prevents patients from attending ED by referring them directly to the area of acute specialist care required, truly ensuring 'Time Matters' for both patients and staff.

  A record 1,150 cases on the ambulance stack were discussed by the multi-disciplinary team in January 2025, leading to over 660 frontline ambulances being diverted to more appropriate services. In addition to providing an improved experience for our patients, this enables crews to treat more patients requiring an ambulance within our system.

  Driving collaboration between the hub and Urgent Community Response (UCR) teams across SNEE has enabled an increase in capacity through an enhanced centralised triage process. This has resulted in approximately a 25% increase of accepted referrals, with over 130 additional patients being treated at home in January 2025, compared to January 2024. In Suffolk, the introduction of a level 1 falls service as well as a GP home visiting car has further facilitated a reduction in unnecessary conveyance to ED and resulted in an improved patient journey.

- **Frailty Rapid Assessment Service** – the service was designed, developed and implemented as a pilot project, launching in October 2024. With over 50% of patients seen by the Community at the Front Door team in Colchester ED residing in Tendring, of which over 85% presenting with a Clinical Frailty Score (CFS) and a Frailty syndrome, purposefully located within the Clacton Urgent Treatment Centre.
  By meeting the key objective of providing same-day specialist frailty assessments to prevent unnecessary acute hospital conveyances and potential admissions, the service has treated over 520 patients between October 2024 and February 2025. Less than 10% required an onward conveyance to the acute hospital.

This assessment service is modelled to accept referrals direct from paramedics with the aim to reduce the number of avoidable ambulance conveyances to Colchester ED. Around one quarter of the total number of patients treated were referred directly from the East of England Ambulance Service NHS Trust which resulted in over 100 patients avoiding an ambulance conveyance to Colchester ED over this period.

Property and Estates

Working closer with one of our national landlords we have managed to reduce the 2024/25 costs compared to 2023/24 by 26% - worth in excess of £1.7m. The property team continue to support clinical and non-clinical services based in community settings, providing expert liaison between landlord and facilities providers and working hard to make improvements to the environment and utilisation of space to support our teams to enhance services for patients.

While it's been a busy year for our new construction projects, our existing stock still needs to be cared for. Our in-house teams have worked around the clock to ensure unexpected breakdowns, plant losses, legislative or good practice maintenance, repairs and small improvement works are completed for the benefits of all our building users.

Major capital projects have been successfully completed, some of which have already been referred to in this report. Others include:

- Child Health Development at Ipswich Hospital – £9.5m - this project incorporated multiple phases and redeveloped and extended the entire Children's department including 24-bed Bergholt inpatient ward, children's outpatient department, short stay paediatric assessment unit (PAU). The project was funded by a combination of capital and charity funding. Charity funding permitted the achievement of colourful and bright décor and furnishings throughout as well as the playground refurbishment and sensory equipment.

- Elmstead Day Surgery Unit improvements at Colchester, providing new staff welfare and rest facilities, remodelled staff booking area, reception refurbishment and toilets. The project also included a new drop off area for ESEOC and Elmstead Day Surgery unit patients along with connecting corridors for both patients and staff to ensure covered access between the Dame Clare Marx Building and the rest of the hospital.
- The Endoscopy Unit at Colchester Hospital
- Urology Investigation Suite at Ipswich Hospital
- Redevelopment of Garrett Anderson Building at Ipswich Hospital.

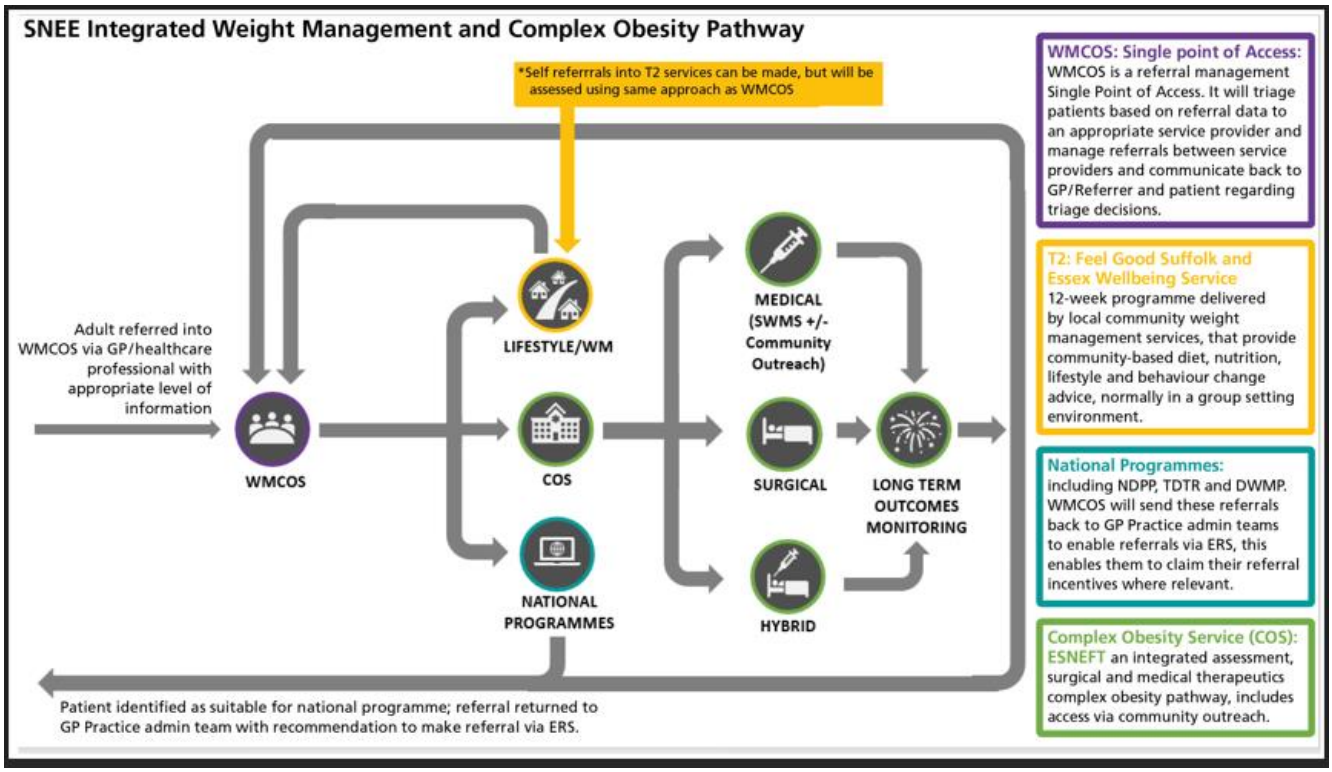
Weight management and complex obesity service (WMCOS)

Obesity affects over 25% of the adult population. This condition is a complex disease and once established it is difficult to reverse through purely diet and exercise. There are links between obesity and other illnesses, and it lowers life expectancy by between five and 20 years – costing the NHS billions of pounds.

Since 2022 significant work has been underway supported by the SNEE ICB, commissioning the Trust to provide a local integrated Complex Obesity Service. We have invested in the recruitment of a multi-disciplinary team and bariatric equipment.

This is the first new service of its kind in the UK in the last 20 years. Patients have transferred from other providers and were dietetically and clinically assessed from August to December 2024. Treatments started in January and the first bariatric surgery took place in March 2025.

We are extremely proud of the progress being made to support our patients. In 2025/26 we will continue to develop the service. Treatment will initially be delivered from Colchester Hospital, but we are looking to open clinics at Ipswich Hospital in a few months' time. Patients will be assessed against the eligibility criteria and will then be referred into the most appropriate treatment for their needs. This is how it works.



Support for our patients and their carers

The people who use our services are central to everything we do. Every member of staff is responsible for ensuring that all our service users have a positive and inclusive experience.

We strive to provide the best possible care and outcomes for the people we care for and believe that involving people who use our services in co-design and co-production is the right thing to do. We remain fully committed to improving patient experience and providing high quality, safe and effective services, whilst putting patients, relatives and carers at the heart of everything we do.

Patient experience means listening to our patients, their family and carers to include them in making decisions about the patient's care. This leads to better health outcomes and an overall improvement in patient experience. While there are different ways to achieve this, it is important we can evidence the steps we are taking to listen to what our patients tell us and to act on their feedback to improve our services. We continue to listen to our patients, relatives and loved ones and aim to make the complaints process accessible and responsive.

The feedback we receive is used to make improvements to our patients' experience, their treatment and care. We collect patient feedback from many sources and use this information to inform service development and improvement programmes, ensuring we include our patients in every decision or improvement we make. Throughout this year, we continued to collaborate with our communities and respond to their feedback and concerns.

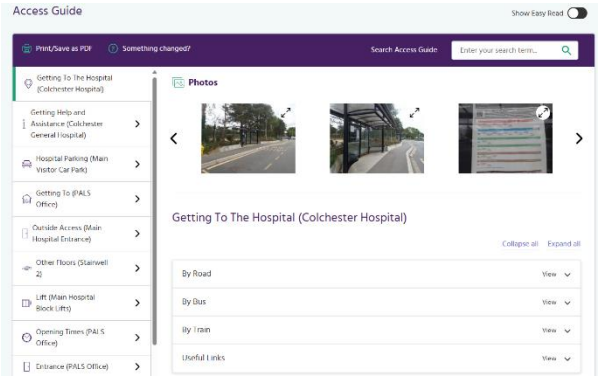
We continue to work closely with our communities and patient representatives. Our patient advocates met with the Head of Patient Experience and with executive directors during the year. We work collaboratively with Action for Family Carers and Suffolk Family Carers to identify and support family carers. The role of the unpaid carer was actively highlighted during Carers' Week in June 2024 and Carers' Rights Day in November 2024 to provide information and advice to support them to make informed decisions about their caring role.

Your experience is our responsibility
Information is an important part of the patient journey and a key element in the overall quality of patient and carer experience of the NHS. It plays a significant part in providing patients and carers with the information they need to make informed decisions about healthcare and give informed consent. We are committed to providing clear, meaningful and accurate patient information, which can be provided in the format most accessible to the individual patient.

We aim to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We take into account the provisions of the Equality Act 2010 and promote equal opportunities for all.

We aim to satisfy the requirements of the Accessible Information Standard (AIS), which ensures that people who have a disability or sensory loss, such as hearing impairment, visual impairment, cognitive impairment, speech difficulty or learning disability, receive information that they can access and understand.

We are committed to ensuring that ESNEFT, as an organisation which provides NHS care and/or publicly funded adult social care, will follow the AIS. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents.

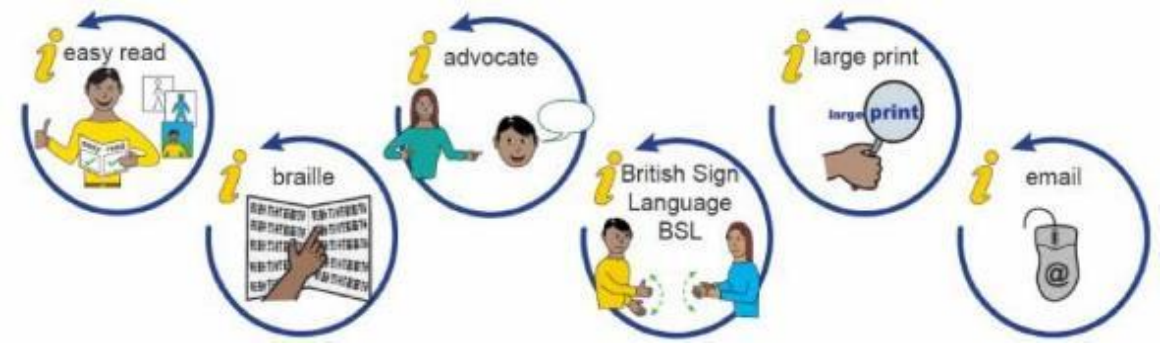


It is important, therefore, that information is presented in an accessible way, and – where appropriate – in a range of languages and formats that are easily used and understood. We believe that providing accessible information will help to improve access to services, promote social inclusion and enable people to make more informed choices about their care. For staff, the provision of accessible information will aid communication with service users, while also supporting choice and reducing inequalities and barriers to good health.

By law, Section 250 of the Health and Social Care Act 2012, all organisations which provide NHS care or adult social care must follow the standard in full. In 2017, NHSE published a revised version of the standard, which requires organisations to:

- Ask people if they have any information or communication needs and find out how to meet those needs
- Record that the question has been asked, even when it is answered with a negative
- Record those needs clearly and in a set way
- Highlight or flag the person's file or notes so it is clear they have information or communication needs and how to meet those needs
- Share people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so
- Take steps to ensure that people receive information, which they can access and understand, and receive communication support if they need it.

This may also include providing information and correspondence in formats patients and carers can read and understand, for example in audio, braille, easy read or large print. Posters have been displayed throughout the organisation offering support to patients where English is not their first language. All documents are provided in Easy Read.



Our patient website is in the process of being developed to meet the Government's WCAG 2.2 Regulations for public service digital platforms in line with W3C recommendations for digital content. The current design and layout of the website will be changed in future to comply with all aspects of these regulations to ensure accessibility for patients whether they have an impairment, learning difficulty or are neurodiverse. We are also working together as an organisation to produce accessible digital documents for download from the website to replace non-accessible print pdf documents. These will function well with third party software to ensure that all information is accessible.

Patient representatives have been involved from the very beginning of the process and have been members of the Patient Experience Group Rapid Decision Making Group, using their lived experience of how they would want the system to work for the benefit of all involved. There will be further requirement for patient user testing in early 2025/26 as the final decisions are made. The Head of Patient Experience will work with Healthwatch to source representatives to ensure we hear from all our community.

Throughout 2024/25, the patient experience team have continued to support events focused on the transition for patients from critical care to ward based care to establish how patients and their families felt supported when the care was "stepped down". Previous Critical Care Unit patients and their families continue to be invited to share their experience with members of staff from the teams at Colchester and Ipswich Hospitals. Feedback gathered from discussions held supports the department to continue ensuring improvement and learning takes place, allowing patients to be honest and open about their care and recovery.

How we monitor patient experience

The Patient Experience Carers and Coproduction Council, chaired by the Chief Nurse, monitors activities relating to learning from, and improving, patient experience. The group meets bi-monthly with staff and patient representation to ensure that the views of the public are heard. The group reviews complaints, compliments, the results of the NHS Friends and Family Test, local and national patient survey results. At each meeting, there is a presentation from divisions highlighting developments, initiatives, learning from complaints and good practice relating to patient experience, including compliments they have received.

The communications team and patient experience team have been supporting the Deputy Chief Nurse with the revised visitor charter. From Thursday 1 May 2025 the Trust will be extending visiting hours on our inpatient wards from 8am to 8pm.The team worked and engaged with patients and staff this year to understand what would better support our patients when spending time as an inpatient. We know that visits from friends and family to patients in our care play a really important part in helping us to provide the best patient care and experience.

The charter outlines the ways in which both our colleagues and visitors can support creating the best atmosphere to help our patients recover. It encourages close working between staff and loved ones to help us understand what extra support the patient may need and who is important in their life.

The charter also asks that our colleagues and those visiting the Trust remain respectful and polite to all those around them and asks visitors for understanding where we may sometimes have to make changes to visiting arrangements where it is best for the patient. It also highlights the ways in which we can all work together to ensure the privacy and dignity of our patients.

Compliments
Compliments are recorded and reported monthly. Feedback, which is posted on online via NHS Choices, Care Opinion and Healthwatch, is collected and shared via the patient experience team.

The Trust received 6,666 compliments in 2024/25. These were received by wards and clinics in the form of letters, cards, gifts, emails, via social media platforms and through the local press. Compliments are provided to the service's senior management team to share with their team to recognise good practice, boost morale and improve staff experience at work. Where individuals have been named they are, where possible, sent a copy of the compliment.

The patient experience team works with patients, relatives and staff and we use their experiences in person, or by video, at the monthly Board meetings.

Accrediting Care at ESNEFT and the Fundamentals of Care Framework

ESNEFT started its Accrediting Care at ESNEFT (ACE) programme in May 2024, after months of researching, planning and networking. The ACE programme provides us with the tools to undertake a comprehensive assessment of quality of care at ward, unit and team levels. It does this by bringing together key measures into a single, overarching framework, from across nursing and clinical care, as relevant to us and our patients.

The ACE team have carried out 14 initial visits since its launch, which includes four pilot wards. Two wards achieved 'working towards bronze, six wards achieved bronze accreditation and two achieved silver accreditations. The team have also carried out three return visits, for those areas working towards bronze and just achieving bronze. These three wards have remained or have now achieved bronze accreditation as a result of the changes they have implemented with their teams.

		Pilot											
	Ward	Haughley	EAU	Peldon	Washbrook	Martlesham	Brightlingsea	West Bergholt	Shotley	Stanway	Waveney	Stowupland	Layer Marney
Standards	Individualised Care	Bronze	Bronze	Silver	Silver	Silver	Working towards Bronze	Silver	Gold	Silver	Bronze	Silver	Bronze
	Dignity and Respect	Working towards Bronze	Working towards Bronze	Working towards Bronze	Bronze	Silver	Working towards Bronze	Silver	Silver	Bronze	Working towards Bronze	Bronze	Working towards Bronze
	Safeguarding, Complex Health and Consent	Silver	Gold	Silver	Silver	Working towards Bronze	Bronze	Working towards Bronze	Bronze	Working towards Bronze	Bronze	Gold	Gold
	Leadership , Education and People	Silver	Bronze	Silver	Silver	Silver	Working towards Bronze	Bronze	Silver	Bronze	Working towards Bronze	Bronze	Silver
	Harm Free Care	Silver	Working towards Bronze	Working towards Bronze	Working towards Bronze	Bronze	Working towards Bronze	Working towards Bronze	Silver	Bronze	Working towards Bronze	Working towards Bronze	Bronze
	Delivering Safe Care	Bronze	Bronze	Silver	Bronze	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Bronze	Working towards Bronze
	Nutrition and Hydration	Gold	Working towards Bronze	Bronze	Silver	Working towards Bronze	Working towards Bronze	Working towards Bronze	Silver	Bronze	Working towards Bronze	Bronze	Working towards Bronze
	Clinical Governance	Silver	Working towards Bronze	Working towards Bronze	Silver	Working towards Bronze	Working towards Bronze	Working towards Bronze	Silver	Silver	Bronze	Bronze	Silver
	Infection Prevention and Control & Environment Safety	Silver	Silver	Bronze	Bronze	Silver	Silver	Gold	Silver	Bronze	Bronze	Working towards Bronze	Bronze
Overall		Silver	Bronze	Bronze	Bronze	Bronze	Working towards Bronze	Bronze	Silver	Bronze	Working towards Bronze	Bronze	Bronze

It was recognised that the standards in the ACE programme and themes from the visits, link closely with the fundamentals of care. The Fundamentals of Care Framework is a conceptual model used in healthcare to guide the delivery of high-quality care. It emphasises the essential elements of care that should be consistently provided to all patients to ensure their well-being and to promote positive outcomes. While specific components may vary slightly depending on the context, the fundamentals typically include:

- Respect and Dignity
- Effective Communication
- Safe and Secure Environment
- Holistic Approach
- Personalised Care Plans
- Promotion of Independence
- Continuity and Coordination
- Safety and Risk Management
- Feedback Improvement
- Ethical Practice.

The priority areas from a ‘fundamentals of care’ survey that was completed by staff and patients/service users were - dignity and respect, effective communication and the safe and secure environment. Of the eight ACE visits that have taken place, ‘Dignity and Respect’, ‘Harm Free Care’, ‘Nutrition and Hydration’ and ‘Clinical Governance’ standards have been rated as working towards bronze for many of the wards visited.

The wealth of data and themes that are being collected and triangulated is stimulating and facilitating an understanding of both the great work and the challenges at ward level, like never before. From this, we are gaining the opportunity to support, encourage and enable wards to achieve continuous improvement.

Given the supportive approach taken with the ACE programme, the patient experience team are now moving the 15 steps programme into ACE, to enhance patient feedback and support opportunities for improvement at ward level.

Some of the work that has been carried out by the patient experience team during 2024/25 includes:

- Involving patient representatives in service improvements and changes
- Sharing patient stories either in person or via video links at every Board and Patient Experience Carers and Coproduction Council Meeting
- Working with our acute hospitals, Healthwatch and learning disability ambassadors to improve the patient experience

- Holding recruitment drives to attract more service users to attend our user groups so we can listen to and engage with patients and carers to embed improvement and change
- Holding complaints training which looked at how we communicate with patients who provide feedback. A revised letter template has been produced as a result and divisions are making courtesy calls sooner to offer meetings to patients and their loved ones. This helps us provide immediate support while reducing the time it takes to complete an investigation. Initial feedback has been incredibly positive
- Working with the QI team looking at new initiatives for QI projects including local and national surveys to ensure triangulation of all data being received as rich information and learning
- The Customer Care Group supporting improvements
- Making Time Matter group looking at how patients and their loved ones can contact the Trust in a timelier manner
- Supporting the safeguarding team in implementing patient user groups to ensure feedback into enhanced therapeutic observation of care.

Complaints and our PALS service
We aim to make the complaints process accessible and responsive. Complaints and the queries and concerns received by our PALS team remain a rich source of feedback for learning and improvement.

The team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters from escalating. This is seen as a positive step towards teams taking more responsibility for issues as they arise.

PALS offers a range of services to patients, relatives, carers and visitors, including:

- Confidential advice and signposting; helping to navigate the hospital and its services
- Feedback: PALS can pass on ideas to improve services
- Addressing non-complex issues informally, often preventing the need to raise a formal complaint.

There were 5,306 PALS contacts in 2024/25, an increase of 8.2% when compared with 2023/24.

During this year, the Trust received 1,286 complaints compared to 1,574 during 2023/24. On average, 95.7% of complaints received were responded to within 28 working days, or an agreed revised timeframe, against a Trust target of 100%.

Every effort is made to contact each complainant within three working days once a complaint has been logged. These courtesy calls are made by a senior divisional manager and are seen as an opportunity to:

- Take time to understand the exact nature of the complaint to help us respond thoroughly and in a meaningful way
- Gain insight to understand the key issues that need to be resolved
- Help build relationships with the complainant so that they feel part of the process while demonstrating that we take their concerns seriously

- Explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example by letter or a face-to-face meeting.

97.5% of courtesy calls were completed in 2024/25.

We have worked hard to improve the quality of complaint responses. However, in some cases, the complainant has remained dissatisfied because not all their concerns were addressed, or they challenged some aspects of the response. In such cases, the complaint has been re-opened for further investigation. Re-opened complaints are generally resolved with either a face-to-face meeting or a further letter of response.

There were 12 complaints re-opened this year.

Referrals to the Parliamentary and Health Service Ombudsman
ESNEFT received a total of 30 contacts from the Ombudsman. Of these, one was an enquiry only, 11 cases were assessed but not taken further to an investigation, four were requests for records and 14 are currently open and under investigation.

Learning from complaints and service improvements
Complaints are an important method by which the Trust assesses the quality of the services it provides. We take all complaints seriously and have taken action to improve care where that has been necessary. We are also working to improve the way we share learning and actions across the Trust.

Patients who raise concerns about their care and treatment should be treated with the utmost respect for taking the time to give us feedback about their experiences. We ensure that complaints are reviewed at divisional clinical governance meetings so that lessons can be learnt and changes made to practice. While information drawn from surveys and other forms of patient feedback is important, every complaint we receive indicates that for that patient or their family, they did not receive the high quality of care they rightly expect.

Lessons learned are identified and discussed at our Patient Experience Carers and Coproduction Council. Monthly dashboard reports have been developed to support the divisions to monitor outstanding actions. Through the divisional accountability process, we expect to see clear evidence of learning from complaints in the future.

Communication remains the highest subject of PALS enquiries and complaints received. To support with improving communication across the Trust, the PALS and complaints team has:

- Created a new, more detailed, information leaflet regarding the PALS service which explains what it can and cannot offer
- Updated the external internet and internal staff intranet pages
- Created an “out of hours” PALS leaflet explaining the help and support available and how to obtain this
- Designed a leaflet in four of our most common languages detailing how support is available for patients or relatives whose first language is not English
- Updated the PALS and complaints easy read leaflet
- Combined the PALS and complaints letter templates, rather than being site specific, to make things clearer and more streamlined for our service users

- Updated the Trust's Concerns and Complaints Handling Policy
- Implemented the Netcall software, which records all incoming and outgoing telephone calls into the PALS and complaints team and allows any member of the team to pick up an incoming call, irrespective of their location. This means callers can speak to the team quickly and easily.

Ongoing training and development of the staff in this team is fully supported and encouraged to ensure their knowledge is maintained and updated to keep customer service levels at the highest possible standard.

Our patients
We have developed ongoing projects with our patients, carers, families and through our patient and public panels. These activities have been led by the patient experience and engagement teams. Some of these projects are ongoing over several years and some are shorter term.

Financial disclosures

HM Treasury cost allocation compliance

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

Political donations

The Trust made no political or charitable donations.

Better payment practice code

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

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

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

	Number	£000
Total non-NHS trade invoices paid in the year	149,167	832,713
Total non-NHS trade invoices paid within target	116,045	747,975
Percentage of non-NHS trade invoices paid within target	77.8%	89.8%
Total NHS trade invoices paid in the year	3,002	94,706
Total NHS trade invoices paid within target	2,339	78,321
Percentage of NHS trade invoices paid within target	77.9%	82.7%

The total potential liability to pay interest on invoices paid after their due date during 2024/25 was £289,431, a reduction on the amount for 2023/24 (£959,605). This is in spite of the prolongation of a high Bank of England base interest rate during the year which reflects the continuation of improved processes at the Trust. There have been minimal claims under this legislation (£7k in 2024/25 and £23k in 2023/24), therefore the liability is only included within the accounts when a claim is received.

Interest rate or exchange rate risks

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

Expenditure on consultancy

Trust expenditure on consultancy in 2024/25 was £258,589, up from £75,506 last year. Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

Nick Hulme
Chief Executive
26 June 2025

Remuneration Report

Annual statement on remuneration

Statement from the chair of the Remuneration and Nomination Committee

The Trust is required to have in place a clear set of principles to guide the committee in a consistent manner and ensure that Very Senior Manager (VSM) salaries remain competitive but have a fair degree of check and challenge associated with performance. This strategy is kept under annual review to ensure alignment with national benchmarking and may be subject to modification in respect to the provision of future guidance from NHSE.

During 2024/25, the Committee has been reconsidering the principles relating to the VSM salary strategy. This work is due to conclude in early 2025/26. No major decisions have been made in relation to remuneration.

In early October 2024, the Committee implemented the recommendation of the 2024/25 annual pay award for VSMs as agreed by the Senior Salaries Review Body, an across-the-board increase of 5% backdated to 1 April 2024.

John Humpston
Non-Executive Director
Chair of Remuneration and Nomination Committee

Senior managers' remuneration policy

The committee decides on the appropriate, structure, size and portfolios of the Executive Team and the remuneration, allowances and terms and conditions of service for the chief executive and other executive directors including:

- All aspects of salary including performance related elements/bonuses
- Provisions for other benefits, including pensions and lease cars
- Arrangements for termination of employment and other contractual terms
- Regular review of the structure, size and composition of the board of directors.

The strategic approach to remuneration was reconsidered and approved in May 2022. As stated above, this is under review based on the principles of equity and transparency, taking into consideration the size, scale and complexity of the organisation as well as the requirement to consider impact on succession planning when setting VSM level pay.

Decisions on executive remuneration are based on available benchmarking information from NHSE, the advice of the executive search firm supporting executive appointments and other market intelligence.

Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust and NHS employment provisions.

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

Contractual compensation provisions for early termination of executive directors' contracts

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

Service contract obligations

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

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

Policy for payment on loss of office

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

Diversity and inclusion

The Trust is committed to encouraging as well as harnessing equality, diversity and inclusion in our workforce. The Board reviews its diversity on a regular basis and collects information about the ethnicity of members. The Trust is conscious that it needs to be representative of the people it serves and encourages applications from people from diverse backgrounds for all vacant posts. External search consultancies that support the Trust's recruitment of VSM staff also provide diversity information in relation to board director and other senior manager applications.

The Trust uses the available data to inform future recruitment exercises so there is a greater focus on attracting a wide diversity of candidates. The right to equal pay is a fundamental principle of the Equality Act 2010 and the Trust reviews the gender pay gap report on an annual basis. Further information can be found within the Equality, Diversity and Inclusion section of this report.

Annual report on remuneration

Details of contracts and notice periods are summarised in the Accountability Report, About the Board.

This Remuneration and Nomination Committee is responsible for advising on the appointment and/or dismissal of executive directors. Board appointments are made through a competitive process following Trust recruitment policies, with remuneration agreed using national benchmarks. The committee approves executive directors' remuneration and terms of service and the monitoring of their performance against delivery of organisational objectives.

The Chair is John Humpston, non-executive director, and the membership comprises all non-executive directors. The Chief Executive is a member for the appointment or dismissal of an executive director and is in attendance. The Director of People and Organisational Development and the Director of Governance attend, and the Trust Secretary is secretary to the committee. The executive directors will be in attendance except when their own terms and conditions are under discussion.

An appointments panel of the committee is convened when executive appointments are to be made. All new, permanent appointments are secured by public advertisement and external assessors form part of the recruitment process.

This year, the committee confirmed appointment to the roles of Chief Nurse, Interim Chief Medical Officer and Interim Deputy Chief Executive. Alumni Global has provided support to the appointment of the Chief Nurse, the Chief Medical Officer and the Director of Estates and Facilities in accordance with the Trust's governance process and as instructed by the Director of People and Organisational Development.

The number of meetings and attendance can be found here.

Fair pay multiple (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024/25 was £300,000-£305,000 (2023/24 was £235,000-£240,000). This is a change between years of 27%, however the identity of the highest-paid director changed between 2023/24 & 2024/25 as a consequence of the Chief Executive working at Norfolk & Norwich University Hospitals NHS Foundation Trust on an interim basis during 2023/24.

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

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £51 to £561,079 (2023/24 £60 to £551,513). The lowest is based on zero hours contracts; if we exclude zero hours the lowest annualised salary for 2024/25 is £16,816 (2023/24 is £10,324).

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 1.1%. A total of nine employees received remuneration in excess of the highest-paid director in 2024/25.

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

2024/25	25th percentile	Median	75th percentile
Salary component of pay	£29,269	£39,032	£50,178
Total pay and benefits excluding pension benefits	£29,269	£39,032	£50,178
Pay and benefits excluding pension: pay ratio for highest paid director	10.34	7.75	6.03

2023/24	25th percentile	Median	75th percentile
Salary component of pay	£27,660	£37,350	£50,991
Total pay and benefits excluding pension benefits	£27,660	£37,350	£50,991
Pay and benefits excluding pension: pay ratio for highest paid director	8.59	6.36	4.66

The percentage change in performance pay is detailed below.

Performance pay movement	Change
Change in performance pay and bonuses from the previous year in respect of the highest-paid director	0%
Average change in performance pay and bonuses from the previous year in respect of all employees (excluding highest-paid director)	-73.3%

The highest-paid director's remuneration was impacted by the award of an inflationary increase in remuneration, in line with the increases awarded to staff more generally. The organisation also had a significant number of successful recruitment campaigns for newly qualified nurses, healthcare assistants and facilities staff, the latter to comply with NHSE new agency rules. This has resulted in an increase in the number of staff in the lower paid bands and ultimately impacted on the median pay threshold.

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

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

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

Salary and allowances of senior managers (subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Helen Taylor	Chair	55-60	800	-	-	-	60-65
Nick Hulme	Chief Executive	300-305	100	-	-	-	300-305
Shane Gordon	Director of Strategy, Research & Innovation	245-250	1000	-	-	-	250-255
Tim Leary (from 12/08/2024)	Interim Chief Medical Officer	105-110	-	-	-	70-72.5	175-180
Adrian Marr	Director of Finance	205-210	100	-	-	-	205-210
Michael Meers	Director of Digital, Logistics & Operations	170-175	-	-	-	-	170-175
Catherine Morgan (from 01/07/2024)	Chief Nurse & Director of Infection, Prevention & Control	115-120	-	-	-	-	115-120
Katherine Read	Director of People and Organisational Development	175-180	-	-	-	120-122.5	295-300
Anne Rutland (01/04/2024 to 30/06/2024)	Acting Chief Nurse & Director of Infection, Prevention & Control	25-30	-	-	-	15-17.5	40-45
Angela Tillett (01/04/2024 to 11/08/2024)	Chief Medical Officer & Deputy Chief Executive	60-65	-	-	5-10	-	70-75
Edward Bloomfield (Leaver 31/10/2024)	Non-Executive Director	5-10	200	-	-	-	5-10
Richard Spencer	Non-Executive Director	10-15	-	-	-	-	15-20
Hussein Khatib	Non-Executive Director	10-15	900	-	-	-	15-20
Mark Millar	Non-Executive Director	10-15	-	-	-	-	10-15
Michael Gogarty	Non-Executive Director	10-15	-	-	-	-	10-15
John Humpston	Non-Executive Director	10-15	-	-	-	-	10-15
David Eagles (from 01/12/2024)	Non-Executive Director	0-5	-	-	-	-	0-5

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Karen Sinnott	Non-Executive Director	10-15	-	-	-	-	10-15
Alex Duffety (from 01/01/2025)	Non-Executive Director	0-5	-	-	-	-	0-5
Usha Sundaram (Leaver 12/02/2025)	Associate Non-Executive Director	5-10	-	-	-	-	5-10

Please note:

- Salaries for Nick Hulme, Shane Gordon, Kate Read and Adrian Marr include pension earn back as a consequence of opting out of the NHS Pension Scheme.
- Adrian Marr and Kate Read rejoined the pension scheme during 2024/25 at which point pension earn back was excluded.
- Salary for Angela Tillett (Chief Medical Officer & Deputy Chief Executive) includes a Clinical Excellence Award (CEA) under long term performance pay in relation to their clinical work.
- Salary for Angela Tillet (Chief Medical Officer) includes her salary for her clinical role, the range of this is £40,000-£45,000 (bands of £5,000).
- Expenses relate to the taxable element of mileage claims made during 2024/25.

Comparative table showing salary and allowances of senior managers in 2023/24

Salary and allowances of senior managers (subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Helen Taylor	Chair	55-60	1100	-	-	-	60-65
Nick Hulme	Chief Executive	170-175	200	-	-	-	170-175
Darren Darby (23/10/23 to 03/03/24)	Chief Nurse and Director of Infection, Prevention and Control	45-50	100	-	-	37.5-40	85-90
Shane Gordon	Director of Strategy, Research and Innovation	235-240	400	-	-	-	235-240
Adrian Marr	Director of Finance	200-205	100	-	-	-	200-205
Michael Meers	Director of Digital, Logistics and Operations	160-165	-	-	-	-	160-165
Neill Moloney (01/04/23 to 12/05/23)	Managing Director and Deputy Chief Executive	25-30	-	-	-	-	25-30
Katherine Read	Director of People and Organisational Development	145-150	-	-	-	15-17.5	160-165
Angela Tillett	Chief Medical Officer and Deputy Chief Executive	200-205	-	-	10-15	-	215-220
Emma Sweeney (14/08/23 to 22/10/23 and 04/03/24 to 31/03/24)	Chief Nurse and Director of Infection, Prevention and Control	30-35	100	-	-	5-7.5	35-40
Giles Thorpe (01/04/23 to 13/08/23)	Chief Nurse and Director of Infection, Prevention and Control	65-70	200	-	-	2.5-5	70-75
Edward Bloomfield	Non-Executive Director	10-15	500	-	-	-	10-15
Michael Gogarty	Non-Executive Director	10-15	-	-	-	-	10-15
John Humpston	Non-Executive Director	10-15	-	-	-	-	10-15
Hussein Khatib	Non-Executive Director	10-15	1200	-	-	-	15-20
Mark Millar	Non-Executive Director	10-15	-	-	-	-	10-15
Fiona Ryder (leaver 31/08/23)	Non-Executive Director	5-10	100	-	-	-	5-10
Karen Sinnott (from 17/04/23)	Associate Non-Executive Director Non-Executive Director	10-15	-	-	-	-	10-15
Richard Spencer	Non-Executive Director	10-15	100	-	-	-	15-20
Usha Sundaram (from 17/04/23)	Associate Non-Executive Director	5-10	-	-	-	-	5-10

Pension benefits (subject to audit)

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

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

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2025 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2025 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2025 £000	Cash equivalent transfer value at 31 March 2024 £000	Real increase in cash equivalent transfer value £000	Employers contributions to stakeholder pension £000
Tim Leary	2.5-5	5-7.5	65-70	170-175	1,539	1,316	76	-
Adrian Marr	-	2.5-5	70-75	210-215	1,908	1,957	-	1
Catherine Morgan	0-2.5	-	50-55	125-130	1,165	1,087	-	-
Katherine Read	5-7.5	5-7.5	40-45	100-105	844	695	98	-
Anne Rutland	0-2.5	0-2.5	35-40	85-90	836	716	15	-
Angela Tillett	-	-	5-10	-	160	114	7	-

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

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

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

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

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

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

Accounting policy for pensions can be found on page within the financial statements.

Governor expenses
Information on the expenses of directors and governors is required by the Health and Social Care Act 2012. Those expenses paid to directors are detailed within the tables above. Membership of the Council of Governors this year in set out here. Six governors claimed expenses between April 2024 and March 2025 of just over £1,200. In 2023/24, claims of c£870 were paid.

Council of Governors' Appointments and Performance Committee

The Appointments and Performance Committee is responsible for advising the Council of Governors on the appointment, termination, performance and remuneration of the non-executive directors including the Chair to meet the Council's general duty.

In accordance with Sections B and E of the Code of Governance for NHS provider trusts 2022, the committee considers NHSE guidance in making appointments, setting remuneration levels and undertaking annual performance reviews for the Chair and non-executive directors. The Trust meets the requirements of the NHS guidance, Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts, November 2019.

The committee met on five occasions in 2024/25. This included reviewing the appraisal outcomes for the Chair and the non-executive directors, appointments and reappointments, and to take forward recruitment of a Trust Chair. The committee provides assurance to the Council of Governors on the robustness of the processes in place when recommendations are presented for approval.

This year the committee has reconsidered the remuneration policy for the Chair and non-executive directors. This review is due to complete in early 2025/26. There have been no changes made to the current policy in-year.

The committee is supported by expert advice from the Director of People and Organisational Development and the Director of Governance.

Membership and attendance are as set out below:

	18/06/2024	08/08/2024	23/09/2024	14/01/2025	19/03/2025	Total
Members (name and job role)						
Helen Taylor, Chair	Yes	Yes	Apologies	Apologies	Yes	3/5
Helen Rose, Public Governor (Lead Governor)	Yes	Yes	Yes	Yes	Yes	5/5
Caroline Bowden, Public Governor, Colchester	Yes				Yes	2/2
Gemma Bourne, Staff Governor, Ipswich	Apologies					0/1
Rebecca Hopfensperger, Appointed Governor, Suffolk County Council			Apologies		Yes	1/5
Light Onyekachi, Staff Governor		Yes	Yes	Yes	Yes	4/4
Pride Mukungurutse, Staff Governor, Colchester	Yes					1/1
Tim Newton, Public Governor, Ipswich	Yes	Yes	Yes		Yes	4/5
Martin Nixon, Public Governor, Rest of Essex						0/1
Gillian Orves, Public Governor, Rest of Suffolk	Apologies					0/1
Isaac Ferneyhough, Staff Governor				Yes	Yes	2/2
Jane Hadlow, Public Governor, Colchester		Yes	Yes		Yes	3/4
Sam Glover, Appointed Governor, Healthwatch Essex				Yes		1/5
Tom Harrison, Public Governor, Rest of Essex			Apologies	Apologies		0/5
Verity Jolly, Public Governor, Rest of Suffolk		Yes	Apologies	Yes	Yes	3/4
Daniel Tweed, Stakeholder Governor, Garrison	Apologies					0/1

Three new appointments were made during 2024/25. This followed a Trust-led, robust appointment process, external advertisement, a majority governor appointment panel and a stakeholder panel. The appointments were supported by Gatenby Sanderson.

Reappointment of non-executive directors after their first three-year term of office is undertaken in accordance with the NHS Code of governance for NHS provider trusts, Section 3: *Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.*

The Trust's constitution confirms: *Subject to satisfactory appraisal, a Non-Executive Director (including the Chair) may be re-appointed by the Council of Governors for a further full term, normally serving a maximum of six (6) years. Exceptionally the Council of Governors may agree to extending the term of office of a Non-Executive Director (including the Chair) by a further twelve (12) months in order to maintain continuity of knowledge and experience within the Board.*

As a new Trust established in July 2018, ESNEFT's first Board was appointed from 11 November 2018. Therefore, six years later, three highly experienced non-executive directors and the Chair reach the end of their terms of office between October 2024 and March 2025. These were judged as exceptional circumstances and the Council of Governors therefore agreed there was a need for stability in the Senior Independent Director role to support the transition to a new Chair. The Council approved an extension of 12 months.

In the event, it was not possible to recruit to the Trust Chair in late 2024 despite a robust recruitment process. A further 12 month extension was considered and approved for Hussein Khatib. Both requests received the required support from the Integrated Care Board and NHSE and were judged to be essential to providing some continuity on the Board.

The Council of Governors has confirmed appointments as follows:

- Reappointed John Humpston and Mike Gogarty for a second three-year term of office
- Appointed two new non-executive directors, David Eagles and Professor Deborah Sturdy, and associate non-executive director Alex Duffety
- Extended the appointment of Senior Independent Director Richard Spencer by 12 months, to 31 October 2025
- Extended the appointment of Hussein Khatib for 12 months, to 4 April 2026
- Appointed Mark Millar as Interim Chair for a period of between six and 12 months, with effect from 1 April 2025.

There have been no changes to the Chair's significant commitments warranting disclosure to the Council.

Nick Hulme
Chief Executive
26 June 2025

Staff Report

The People Strategy

Every day our staff deal with the pressures of the ever-increasing demand for our services, and they are vital to our continued success. In order to be able to respond to the future challenges we face and take the high standard of care we provide to the next level, the right training and development opportunities and wellbeing support need to be available to our staff.

The People Strategy, which was produced in 2020, was reviewed in the winter and focusses on four key strategic themes and priority areas. These align with the priorities of the NHS Long Term Workforce Plan and the People Promise areas. The headlines are listed below:

NHS Long Term Workforce Plan

- Train and grow our workforce
- Retain and embed the right culture and thus improve retention
- Reform by working and training differently; and
- ICS engagement to produce a Joint Forward Plan which will support sustainable employment of local communities.

People Promise Themes

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

The strategy framework will ensure that the lived experience of staff working at ESNEFT is both fulfilling and inspiring, where all staff have a sense of pride and purpose in their work and where contribution to the development of services for the communities we serve is appreciated and valued.

Supporting our leaders

Our bespoke values based supportive leadership 360 review programme went live in September 2024, with our first project covering Advanced Nurse Practitioner colleagues. We have 17 actively engaged trained feedback facilitators, who support our leaders once their 360 report is generated, guiding them through the results and discussing areas of particular focus for growth in a one-to-one discussion. The reports help leaders understand how to develop and strengthen their leadership behaviours and qualities.

Our commitment in strengthening a compassionate and inclusive culture through developing leadership behaviours that are aligned to our OAK values and the NHS People Promise continues into 2025 with a revamp of our Leadership Charter. Leaders in ESNEFT are expected to demonstrate our leadership qualities always underpinned by our OAK values and take all necessary steps to develop their leadership skills.

To support them in achieving this, they will need to:

- Attend a leadership on-boarding session
- Attend a leadership programme relevant to their banding
- Attend relevant masterclasses within a set timeframe, supporting new and existing managers to develop skills in areas such as conflict resolution, managing high performing teams, supporting psychologically safe working environments, etc
- Take part in a supportive 360 leadership review
- Keep a CPD record of all additional leadership training or online learning
- Identify additional training and/or apprenticeship opportunities that will support their own development through a My Career Matters conversation
- Review their leadership development at the time of their appraisal.

Revised leadership charter
Our Leadership Charter outlines the qualities we want leaders to aspire to, providing them with a framework of behaviours which are underpinned by our OAK values. It serves as a guide for leadership conduct aligning our leaders to a compassionate and inclusive culture for our staff, patients and their families and carers.

Leadership qualities that I will be competent in	Leadership responsibilities – what I am accountable for	Leadership actions – what I will do
Ethical *To lead with honesty, act fairly and consistently with a sense of loyalty towards others*:	• Act in the interests of the individual, the team and the Trust • Role model our leadership charter • Follow through with my commitments • Welcome differences and embrace the presence of others, celebrating the experience they bring.	• Ensure that I make time for open and honest conversations • Instil a culture of compassion and fairness in the working relationships of my team • Provide a safe space for my team to raise concerns • Follow all relevant policies and procedures to maintain diversity, equity and inclusion

Leadership qualities that I will be competent in	Leadership responsibilities – what I am accountable for	Leadership actions – what I will do
Collaborative *To nurture and secure trusted relationships*:	• Work with own and other teams within the Trust and across the sector to share ideas and best practice • Identify ways in which collaboration can benefit all areas • Communicate clearly and timely Trust expectations to the team and wider colleagues • Listen and empathise when my team are experiencing difficulties and work to find a resolution	• Attend leadership briefings and events to keep my team up to date with national, regional and Trust initiatives • Develop, review and maintain agreed ways of working • Act in the interests of my team to ensure our work is recognised and acknowledged • Advocate for under-represented groups, both staff and patients
Adaptable *To model behaviour that encourages and embraces innovation and change*:	• Be available and make time matter • Lead change and new initiatives positively • Be open to new ways of working	• Encourage innovation and support team ideas for improvement • Adjust my approach according to the situation, making sure I am making appropriate decisions which are evidenced based
Inspirational *To be a positive influencer and a catalyst for growth*:	• Empower others to have the confidence to take appropriate actions • Being enthusiastic about helping others to grow in a healthy and well-balanced manner. • Take actions that will support my team and drive performance and achieve targets • Explore opportunities before considering the constraints/limits	• Be the first to undertake new training when available • Support opportunities for staff to develop career pathways within the Trust to maintain continuity and retain talent • Encourage and drive professional development in my team

Freedom to speak up and raising concerns

The Board re-endorsed the Freedom to Speak Up (FTSU) vision statement in November 2024.

'*We encourage our staff to raise concerns openly or anonymously if they prefer, safe in the knowledge they will be supported if they do. This will help us to make ESNEFT a positive and trustworthy place to work and receive care.*'

The Board has re-energised the FTSU Steering Group which now has a strategic focus and meets six monthly, normally before the FTSU Guardian appears before the People and Organisational Committee and in preparation for their appearance before the Board held in public. The self-reflection and planning improvement tool is now completed annually and allows the Trust to identify areas of good practice and address those areas of concern. The Board approved the most recent self-assessment in November 2024.

One of the positive elements highlighted by the review was the continuing success of an anonymous follow up survey, which we now send to everyone who raises a concern so that we can further improve our processes and the support which is in place. This has been coupled with a renewed emphasis on multi-disciplinary sharing of data to review hotspots and to target areas of concern.

Our FTSU guardian continues to work closely with the equality, diversity and inclusion (EDI) team and is a member of the EDI Strategic Reference Group. Assistant guardians continue to work within the EMBRace and ESNAble networks, giving people from an ethnic or disabled background who might struggle to raise concerns a clear route to do so in a comfortable and safe setting. Of particular note are both the appointment of a Deputy FTSU Guardian and an assistant guardian within the junior doctors grouping.

In the coming year we will look to reorganise our network of assistant guardians and in particular look at having representatives in each of our outstations such as Clacton, Harwich and Felixstowe. We currently have 13 in post. We have also adopted the new national Freedom to Speak Up policy and are a founder member of the East of England Freedom to Speak Up Network. We will continue to raise awareness of the importance of speaking up through various events, visits and tailored presentations to specific staff groups.

Staff information

On 31 March 2025, the Trust directly employed 12,991 staff (11,395.48 full time equivalents (FTE)).

We have reviewed acuity staffing levels on the wards, resulting in an increase in the establishment required to meet patient need safely along with additional services TUPE'd in [Transfer of Undertakings (Protection of Employment)].

	Number of Trust staff		
	Headcount	Establishment (FTE)	Staff in post (FTE)
31 March 2025	12,991	12,269	11,395.48

Staff costs (subject to audit)

	2024/25		
	Permanent (£000)	Other (£000)	Total (£000)
Salaries and wages	505,588	16,575	522,163
Social security costs	54,318	0	54,318
Apprenticeship levy	2,641	0	2,641
Employer contributions to NHS Pension Scheme	99,939	0	99,939
NEST pension contributions	104	0	104
Termination benefits	435	0	435
Agency/ bank staff	0	60,147	60,147
Total	663,025	76,722	739,747

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

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

Average number of employees (FTE basis)	2024/25		
	Total	Permanent	Other
Medical and dental	1,455	522	933
Administration and estates	2,890	2,615	275
Healthcare assistants and other support staff	2,490	2,145	345
Nursing, midwifery and health visiting staff	3,703	3,290	413
Scientific, therapeutic and technical staff	1,174	1,088	86
Healthcare science staff	329	306	23
General payments (non-executives)	9	9	0
Total average numbers	12,050	9,975	2,075

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

Sickness absence

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE for 2024	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Sick Days per FTE
10,877	111,696	3,970,226	181,196	10.3

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2024
Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:
The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.
The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.
The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Staff exit packages (subject to audit)

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

	2024/25		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	0	47	47
£10,001 - £25,000	0	3	3
£25,001 - £50.000	0	3	3
£50,001 - £100,000	1	0	1
£100,001 - £150.000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	1	53	54
Total resource cost (£000)	51	327	378

	2023/24		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	0	44	44
£10,001 - £25,000	0	8	8
£25,001 - £50.000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150.000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	0	52	52
Total resource cost (£000)	0	270	270

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

Non-compulsory departure payments

	2024/25		2023/24	
	Number	Cost (£000)	Number	Cost (£000)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	53	327	52	270
Exit payments following employment tribunals or court orders	0	0	0	0
Non–contractual payments requiring HNT approval	0	0	0	0
Total	53	327	**52**	**270**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Redundancy and other departure costs have been paid in accordance with the relevant NHS provisions. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or full in a previous period.

Equality, diversity and inclusion

The Public Sector Equality Duty was created not only as a statutory reporting requirement to have due regard to the duties laid out in the Equality Act 2010, but it also provides assurance that the Trust is committed to eliminating discrimination, harassment and reducing health inequalities by promoting equity of opportunity and dignity and respect for all our patients, service users, their families, carers and our people.

The key responsibilities for ESNEFT, as one of the largest employers in the region and provider of services, are:

- to call out inequity wherever we see it
- take the appropriate actions; and
- most importantly proactively promote inclusion and respectful interactions for all of our colleagues, patients and service users.

We want it to help drive our performance and to enable us to meet our commitment and passion to make a difference to the lives of our staff, patients and the diverse communities we serve.

Our Public Sector Equality Duty report was considered by our Board in October 2024 and confirmed for publication on our website. The report provides details of our workforce and service user data as required by the Equality Act 2010 (specific duties) and demonstrates how we have continued to work hard to provide increased visibility and focus to the Trust's EDI agenda and work plan:

- Supporting and further establishing our staff networks
- Continuing to establish and embed the role of our Cultural Ambassadors
- Working closely with external partners including locally based The OutHouse who support us with our policies and processes to ensure they are inclusive from lived experience expertise, as well as Nottingham and Essex Universities as part of the Dare to CARE (Creating and Anti-Racist Environment) programme
- Embedding a suite of EDI bite size training programmes available to all staff has enabled around 2700 to participate over the past year
- Holding listening events for staff to raise concerns or suggestions that may improve staff experience
- Bespoke intervention sessions for teams or departments.

We introduced an Equality Impact Assessment process for new or revised policies, processes, procedures and/or service redesigns to ensure the equality of service delivery to different groups has been promoted through the organisation. This ensures that due regard to the aims of the Public Sector Equality Duty is considered where applicable in terms of any barriers or inequalities within our current practices and addressed or mitigated whilst also adhering to the FREDA principles (fairness, respect, equality, dignity and autonomy).

Whilst we have made incredible progress in terms of ensuring that equality is at the fore of all that we do at ESNEFT, we recognise we are still at the early stages of our EDI journey. However, we are committed to working with all of our stakeholders and our strategic partners, regionally and nationally, to improve equality outcomes for all and our continued collaborative work to support the NHS EDI Improvement Plan and high impact actions. This work is supported by Non-Executive Director Hussein Khatib.

Our staff networks

Our Women's Network is the latest addition to a fantastic group of existing staff diversity networks which are thriving at ESNEFT. The staff networks act as key enablers for staff engagement in terms of understanding the lived experience of our staff and how some protected characteristics and circumstances may impact on staff experience. Our networks help to raise awareness and highlight issues so that we can respond with initiatives that will enhance inclusive cultures and ultimately improve staff and patient experience.

Women's Network

The Women's Network was launched in May 2024 with a motivational event that focussed on fostering connection, collaboration and conversation. We were joined by two truly inspirational speakers who gave their expertise, insight and direction of conversation around leadership, change and dialogue to encourage speaking up within the organisation and listening to diverse voices who may be excluded. We also learnt about identifying what balance means to individuals and the five steps to achieving it so that women at ESNEFT can reach their full potential and lead happier and healthier career and personal lives.

Approximately 200 women from the Trust attended the event and are now active members of the network. This provides opportunities to discuss meaningful topics in the workplace and share experiences, building network connections, nurturing wellbeing and giving people the tools they need to achieve development and growth.

The Network celebrated International Women's Day with network stands on both sites to promote the various ways in which the Trust is supporting gender equality with coaching and mentoring, career and personal development opportunities as well as our in-house apprenticeship and leadership development programmes. There was also a focus on health and wellbeing support available to all staff.

ESNAble

The network has been pivotal in receiving and utilising feedback from staff on their lived experience of having a disability or long term condition which is helping the Trust to shape our policies and processes to be more inclusive and supportive and form an organisational approach to the recruitment of people with a disability or long term condition which is fair, equitable and accessible to all applicants and ensuring we do not disadvantage or discriminate against any cohorts due to their protected characteristics. ESNAble members have been instrumental in re-designing our Reasonable Adjustments Passport and supporting guide for managers of people with a disability or long term condition.

The network leads have been busy providing a safe space for staff to seek advice on reasonable adjustments and signposting to external support provisions such as Access to Work applications and local schemes. It also established disability awareness sessions designed to help break down barriers and empower all staff in having open and confident conversations around disability; as well as sharing useful links to information and resources to celebrate UK Disability Month.

LGBTQ+ Friends

During the year, the LGBTQ+ network appointed a new chair and vice chair and rolled out the network work plan which included a Pride event with our other EDI networks to celebrate all things LGBTQIA. Staff were invited to share their Pride Stories, hold safe, inclusive conversations and shared experiences and encourage intersectionality. The network received really positive feedback from attendees.

The network also promotes in-house, regional and national projects taking place to share learning and has continued to roll out key training to staff to support our newly introduced inclusive pregnancy status form for patients. LGBTQIA awareness sessions have continued throughout the year and help break down barriers and further support awareness and care to our patients. The sessions include establishing preferred pronouns, preferred gender identity and an understanding of the transgender pathway.

The network has continued to develop its plan for 2024/25 to include joining Pride in Veterans to ensure we can best support LGBTQ+ veterans at all stages of their journey; it has also worked on the recommendations from the assessment by the NHS Rainbow Badge scheme, which include the establishment of gender neutral toilets, baby changing areas and baby feeding facilities.

EMBRace

Our EMBRace network, which supports our staff from ethnic backgrounds, has continued to celebrate equality, diversity and inclusion whilst supporting us to achieve our EDI strategy objectives. The network has led on celebrations throughout the year:

- Asian Heritage celebration which included a colourful event of entertainment, food and networking opportunities
- October was Black History Month where inspirational staff stories were shared
- Our onsite restaurants creative a festive menu to celebrate Chinese New Year
- Celebrated Race Equality Week by promoting the Race Equality Matters 5 Day Challenge. This aimed to acknowledge the many barriers to driving race equity, including a lack of understanding of what it feels like to be in the others' shoes and how to be positively inclusive
- Promoted the NHS Muslim Network guidance documents to support Muslim colleagues, allies and friends through Ramadan. The guides provided awareness on Islam and the requirements of Muslim staff at work during this religious period of fasting.

Armed Forces

We have continued our collective ambition of growing armed forces support in our communities. As part of this, we have celebrated/commemorated key events such as:

- D-Day 80 - in May 2024 we marked the 80th anniversary of the Normandy Landings. Commemorative services were held at Ipswich and Colchester hospitals. Colleagues joined the nation remembering and honouring those who have sacrificed themselves to secure and protect our freedom by lighting a lamp of peace
- Armed Forces Day - in June, we demonstrated support to our Armed Forces community hosting a week of celebrations. During this week we also celebrated national Reserve Day, inviting Garrison representatives from 161 Medical Squadron to host a recruitment stand at Colchester hospital.

- Act of Remembrance - in November we held services of Remembrance at Ipswich and Colchester hospitals. Garrison representatives were invited and were in attendance at both sites. Following the service, our Armed Forces Network hosted coffee mornings for members and invited guests.
- NHS Insight event - in February our Armed Forces Network hosted an NHS insight event at the Iceni Centre in Colchester. This event was for Military personnel attending a transition course at the Recovery Centre located at Merville Barracks. Recruitment, Talent for Care and the Step into Health team supported this event alongside out network members.

Staff Carers Network
This is the latest addition to the staff networks and was launched in early 2025 recognising that many of our staff also have carers responsibilities for loved ones outside of the workplace and the impact this can often have on their own wellbeing when trying to balance home and work life.

The network is fortunate to have our Chief Executive as the Senior Responsible Officer. It provides monthly sessions where staff benefit from peer-to-peer support and advice and a safe space to be open about their experiences and the vulnerability that this often brings.

Workforce Race Equality Standard (WRES)

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

Over the past year we have continued our work to improve race equality with talent and career development of black and minority ethnic (BAME) staff, including coaching, mentoring and access to continued professional development opportunities to work towards:

- improving representation across senior levels of the organisation
- promoting and valuing the voice of BAME staff within our decision-making committees and processes
- promoting Allyship and speaking up
- supporting managers to understand structural and individual acts of racism and monitor the development of our cultural intelligence programmes (Cultural Ambassador Programme, Reverse Mentoring and Talk to Transform) in order to reduce all forms of discrimination in the workplace.

More information is available on the EDI section of our website.

Workforce Disability Equality Standard (WDES)

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

We have continued to enhance our policies and practices over the last year to ensure opportunity and inclusion, particularly around career progression, for all disabled staff; strengthened our procurement process making it easier to purchase reasonable adjustments; implemented the role of Wellbeing Ambassadors with around 80 staff volunteers; and continuing to implement the recommendations required to attain Level 3 Disability Confident Employer status. More information about WDES is available on the EDI section of our website.

Gender Equality

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

We continue to meet our responsibilities under gender pay gap reporting with details from the last report available on the EDI section of our website.

The table below shows the breakdown of male and female executive directors, other senior managers and employees. Directors who were on interim off-payroll contracts and the non-executive directors as of 31 March are not classed as employees and are not therefore covered in the total number of staff employed by the Trust, a figure of nearly 13,000.

Role	Female	Male	Notes
Non-executive directors	3	6	Includes Chair
Executive directors	3	6	Includes Chief Executive
Other senior managers	34	23	Bands 8d and above
Employees	9,917	2,999	
Total	9,957	3,034	

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

Policies

Following the sign up to the Race Equality Charter and Sexual Safety in Healthcare Charter we strengthened our Bullying and Harassment policy and added a Sexual Safety toolkit. These have been promoted to all staff via bite-size training sessions which educate staff around what constitutes acts of sexual harassment and assault, how to report an incident, and how the individual will be supported i.e. psychological support and signposting to resources by our Wellbeing Hub.

Our revised equality impact assessment form has continued to be used to complete an equality analysis when reviewing policies, projects or when planning changes to services as part of organisational change processes. This ensures that our functions and services are not discriminating or disadvantaging particular cohorts of staff, patients and service users by protected characteristics under the Equality Act 2010.

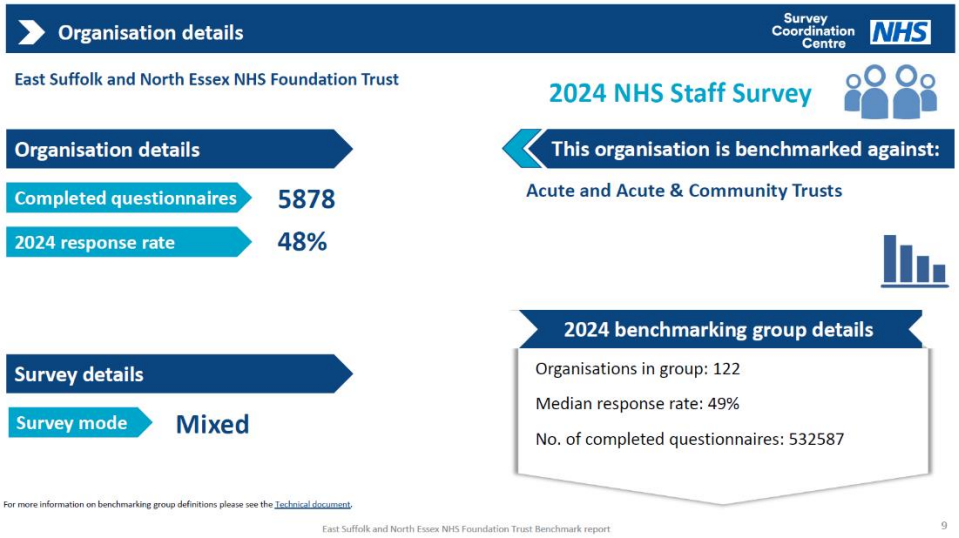
Staff survey

The NHS Staff Survey is conducted annually. Whilst we have not seen any significant changes in the seven People Promise themes against our own scores from 2023, we have scored significantly better in three areas against average sector scores:

- Morale
- We are recognised and rewarded
- We work flexibly.

As a Trust we consider our 2024 position as 'maintaining' compared to 2023, where we saw such sweeping improvements. We remain optimistic and are keen to see more improvement throughout 2025. The full report for this year's survey is available at www.nhsstaffsurveys.com

A usable sample of 12,220 copies were distributed to all eligible staff. From this sample, 5,878 questionnaires were returned yielding a response rate of 48.1%. This compares to 4,405 returns (38.8%) in 2022/23 and 6,073 returns (51.8%) in 2023/24



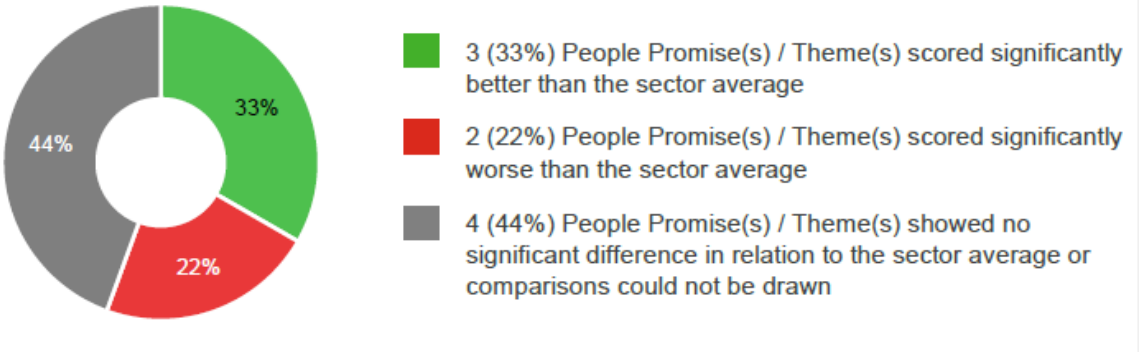
The NHS Staff Survey continues to align to the seven themes of the NHS People Promise and has done so since 2021. Results can be used to support further improvements and are benchmarked against previous years. The People Promise is a unifying framework that creates a standardised way of measuring, understanding and improving employee experience across the NHS in England. It sets out, in the words of NHS staff, the things that would most improve their working experience.

The table below highlights our scores across each of the seven themes benchmarked against the previous year and the average sector score.

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
Theme - Staff engagement	6.84	Not Significant	6.80	Significantly Worse	6.85
Theme - Morale	6.01	Not Significant	6.00	Significantly Better	5.93
People Promise 1 - We are compassionate and inclusive	7.26	Not Significant	7.23	Not Significant	7.22
People Promise 2 - We are recognised and rewarded	5.98	Not Significant	5.97	Significantly Better	5.90
People Promise 3 - We each have a voice that counts	6.69	Not Significant	6.65	Not Significant	6.68
People Promise 4 - We are safe and healthy	6.09	Not Significant	6.10	Not Significant	6.09
People Promise 5 - We are always learning	5.58	Not Significant	5.59	Significantly Worse	5.69
People Promise 6 - We work flexibly	6.28	Not Significant	6.29	Significantly Better	6.22
People Promise 7 - We are a team	6.76	Not Significant	6.76	Not Significant	6.74

Key highlights:

- The majority of our People Promise scores this year are in line with the sector scores for similar organisations surveyed by our independent staff survey coordinator IQVIA
- Our scores for the following People Promise themes were significantly better than other organisations:
    - We are recognised and rewarded
    - We work flexibly are significantly
    - Morale
- For the theme ‘We are always learning’ the score is significantly worse
- The staff engagement theme is significantly worse than the sector score, whereas morale is significantly better
- Where comparable to 2023, three question-level scores have declined although there have been five significant improvements. The declines include health and wellbeing and receiving respect at work.



Comparison to previous year - significant difference in scores
The tables below show where questions have shown statistically significant improvement/decline since the 2023 survey.

Our 2023 and 2024 scores are shown side by side, with the percentage difference between the two represented by the coloured bar to the right.

2024 score analysis	2023 score analysis
5 (5%) question(s) have shown significant improvements since 2023	(68) 65% of questions answered have shown significant improvements since 2022.
3% question(s) have shown significant declines since 2023	1% of questions has shown a significant decline
99 (93%) question(s) have shown no significant movements since 2023 or score is suppressed	(35) 34% questions have shown no significant movement since, or the score is suppressed

Significantly better scores

Question		2023	2024	Difference
6d	I can approach my immediate manager to talk openly about flexible working.	68.0%	69.8%	+1.7%
10b	I work additional PAID hours for this organisation, over and above my contracted hours.	38.7%	36.8%	-1.9%
14a	In the last 12 months, I have personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public.	28.6%	26.4%	-2.3%
17a	In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public.	10.2%	8.7%	-1.5%
24e	I am able to access the right learning and development opportunities when I need to.	56.6%	59.4%	+2.8%

Significantly worse scores

Question		2023	2024	Difference
7c	I receive the respect I deserve from my colleagues at work.	73.2%	71.5%	-1.6%
11d	In the last three months I have come to work despite not feeling well enough to perform my duties.	53.4%	55.6%	+2.2%
25f	If I spoke up about something that concerned me I am confident my organisation would address my concern.	47.7%	45.7%	-2.0%

Staff Engagement scores

This is measured as an average across three sub-scores:

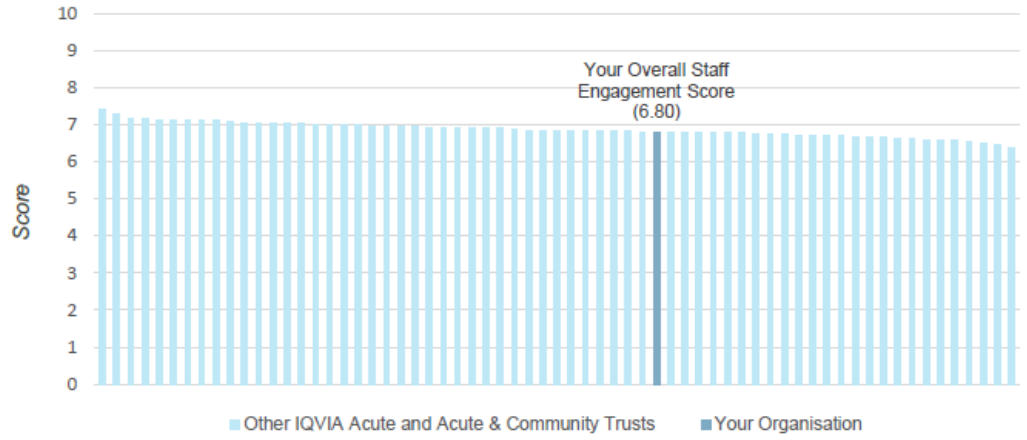
- Advocacy - staff recommending the organisation as a place to work or receive treatment
- Motivation - staff motivation at work
- Involvement - staff's ability to contribute towards improvement at work.

Staff engagement scores fall between 0 and 10, where higher scores indicate higher engagement among staff. Significant differences between the years have been indicated.

The graph below shows the range of staff engagement scores across the acute and acute and community sector in ranking order.

The ESNEFT score is (6.80) and our position within the sector is marked with the darker line. The lighter blue bars represent the scores of other organisations within our sector.

	2024 Score	2023 Score	Diff	Sector Score	Diff
Motivation	7.00	7.03	-0.03 (Not Sig.)	6.94	+0.06 (Sig.)
Involvement	6.83	6.85	-0.02 (Not Sig.)	6.81	+0.02 (Not Sig.)
Advocacy	6.56	6.64	-0.08 (Sig.)	6.80	-0.24 (Sig.)
Overall Staff Engagement	6.80	6.84	-0.04 (Not Sig.)	6.85	-0.05 (Sig.)



Morale sub-scores

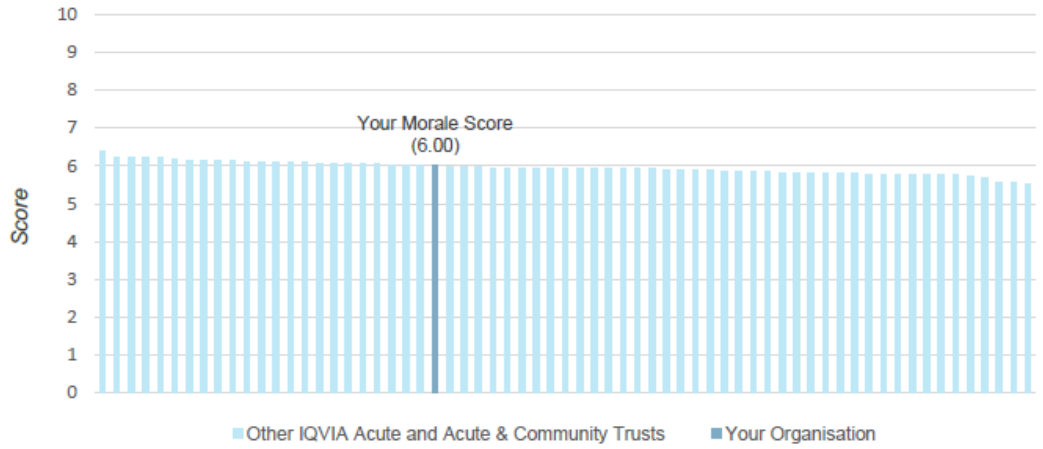
Morale is measured as an average across three sub-scores:

- Thinking about leaving (the organisation).
- Work pressure (staff having the resources to do their work)
- Stressors (Health and Safety Executive Index, indicators of stress).

Morale scores fall between 0 and 10, where higher scores indicate higher morale among staff. Significant differences between the years have been indicated.

The graph/table below shows the range of morale scores across the acute and acute and community sector in ranking order. ESNEFT's score is 6.00 and our position within the sector is marked with the darker stripe. The lighter blue bars represent the scores of other organisations within our sector.

	2024 Score	2023 Score	Diff	Sector Score	Diff
Thinking about leaving	6.19	6.24	-0.05 (Not Sig.)	6.06	+0.13 (Sig.)
Work pressure	5.41	5.36	+0.05 (Not Sig.)	5.36	+0.05 (Not Sig.)
Stressors (HSE index)	6.41	6.42	-0.01 (Not Sig.)	6.39	+0.02 (Not Sig.)
Morale	6.00	6.01	-0.01 (Not Sig.)	5.93	+0.07 (Sig.)



The work of the Organisational Development and Culture team focuses on improving Trust effectiveness by enhancing employee experience and implementing strategies for long-term growth. The way we support our people to transform systems within which we work is key to our success. Our workforce engagement strategy continues to directly link to this, an individual's motivation to work hugely impacts and ultimately affects our ambition to deliver the very best possible care to our patients and their families.

We continue to support teams with defining and embedding our OAK values in all they do. We promote equity, inclusivity, diversity, and employee wellbeing. We help teams to develop strategies to manage resistance and enhance engagement, ensuring that our leaders and employees adapt successfully to change. We continue to work in close collaboration with our Faculty of Education colleagues to design and implement our leadership development programmes. Our My Career Matters programme helps us identify high-potential employees and to nurture their growth. Our facilitation of awaydays helps improve team collaboration and cross-functional efficiency. We implement strategies for continuous learning and innovation.

Next steps

Our staff survey results are an invaluable tool for helping us understand the Trust's pulse and identifying areas for improvement. For 2025 we will continue to focus on four of the five main priority areas identified in 2024 as whilst there are areas that have clearly improved there are still areas where we need to see greater improvement.

1. We are compassionate and inclusive (diversity, equity and inclusion)
2. We have a voice that counts (confidence in raising concerns)
3. We are safe and healthy (burnout)
4. We are always learning (appraisals)

We are supporting divisions to review their own results. Human Resources (HR) business partners will work with divisions to consider what they can do to improve across the four main themes.

We will share good practice and celebrate improvements for exemplar areas.

We are engaging with teams and areas where there was poor uptake of the survey to encourage a greater return next year. Exploring the barriers as to why they chose not to participate will enable us to confirm what we can do to support and encourage them to take part in 2025.

Trade union facility time

Staff Partnership Forum

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

The Staff Partnership Agreement, which will be reviewed in 2025/26, sets out the specific responsibilities and purpose of the group which, in summary, is to promote good employee relations and maintain a positive, constructive and trusting relationship between the Trust and staff side through:

- Information: Keeping all parties fully informed of relevant matters at the earliest opportunity. This will include the forum receiving and discussing reports upon the Trust's planning and workforce intentions, financial position and other relevant management issues. Matters can be raised by either party.
- Consultation: To be given every reasonable opportunity to provide feedback on and to be consulted upon relevant proposed management decisions, such as organisational change and non-contractual employment policies and procedures.
- Negotiation: For the purpose of reaching agreements and avoiding disputes for matters concerning interpretation and implementation of collective agreements or contractual terms and conditions of employment.

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

Role	Agreed time
Staff side chair	4 days per week
Deputy staff side chair	2 days per week
Senior steward – community	1 day per week
UNISON branch secretary	3 days per week
RCN (Royal College of Nursing) lead steward	1 day per week
Total dedicated time	**11 days**

Number of employees who were trade union officials	Whole time equivalents
32	27
Percentage of time spent on facility time	**Number of employees**
0%	29
1% - 50%	0
51% - 99%	1
100%	2
Total cost of facility time	**Costs**
Total pay bill	£739,747,000
Percentage of pay bill spent on facility time	0.013%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
	15.4%

Off payroll engagements

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater	
Number of existing engagements as of 31 March 2025	0
Of which...	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0
All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2025	0
Of which:	
Not subject to off-payroll legislation	
Subject to off-payroll legislation and determined as in-scope of IR35	
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025	0
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

The Code of Governance for provider trusts

ESNEFT has applied the principles of the code of governance for NHS provider trusts, published on 27 October 2022, and applicable from 1 April 2023. The Board has departed from the code on a 'comply or explain' basis as follows:

- Section B, 2.5, the Chair of the Audit and Risk Committee should, ideally, not be the Deputy Chair.
- Section D, 2.1, the vice chair or senior independent director should not chair the audit committee.
    - Previously reviewed and considered that the risk would be greater to move one of these roles to another non-executive director. Reconsidered in 2024 and, given the number of changes in the non-executive directors in the next 12 months, and that the current Audit and Risk Committee Chair is now in his second three year term of office, the requirement for recent and relevant financial expertise to chair the Audit and Risk Committee formed part of the appointment process for new non-executive directors during the autumn 2024. This has been resolved with effect from 1 April 2025 when David Eagles, a new non-executive director, takes over as Chair of the Committee.
- Section B, 2.6, the board of directors should identify in the annual report each non-executive director it considers to be independent – has served on the board for more than six years from the date of their first appointment.
- Section C, 4.3, any decision to extend a term beyond six years should be subject to rigorous review
    - Two non-executive directors' terms of office have been extended for an additional 12 months, to seven years, as described earlier in this report. This was due to exceptional circumstances and to ensure stability on the Board and was approved by the ICB and the NHSE Regional Director.
- Section C, 5.15/5.16, where appropriate the board of directors should in a timely manner take account of the views of the council of governors on the forward plan.
    - The Council of Governors work programme now includes a formal discussion on the Trust's strategy at least annually, most recently received in December, and an update was provided on the Trust Plan submission in March 2025. Members of the Council also met with West Suffolk NHS Foundation Trust Governors to receive an update on the collaborative work undertaken between the two Trusts. A further joint briefing is scheduled for early in 2025/26, ensuring this requirement is fully met.
- Appendix B: Council of governors and role of the nominated lead governor, 3.3, provision of agenda prior to any meeting of the board and a copy of the approved minutes as soon as is practicable afterwards.
    - A link to Board papers is shared with the Council including the draft minutes of the previous meeting. Governors are briefed on relevant Board discussion held in public through a Board proceedings report to Council. In relation to Board discussions held in private, there are informal meetings held with the Chair and non-executive directors. The Lead Governor is kept updated on developments through regular meetings with the Chair. Up to two governors are identified to attend Board assurance committees as observers and as such are party to the detailed discussions. A Board proceedings report in relation to discussion held in private has been presented to Council in private from September 2024.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

During 2024/25 the Trust was allocated to segment 2. Current segmentation information for NHS trusts and foundation trusts is published on the NHSE website: https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/

The Trust has reviewed in detail the NHS Provider Assessment Framework for 2025/26 and awaits implementation of the final framework in July 2025.

Modern Slavery Act 2015 and Human Trafficking Statement

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) aims to deliver high-quality services for all, and we do this by ensuring that our workforce has the right numbers, skills, values and behaviours to support the delivery of excellent healthcare and health improvement to patients and the public.

The Trust is committed to utilising the funding it receives to provide healthcare to our local communities in an efficient, effective and responsible way and enables vital supplies to be delivered to the organisation without disruption, so that frontline staff can focus on providing world-class patient care.

ESNEFT fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role that NHS organisations must play in both mitigating it and supporting victims. This includes a commitment to ensure our supply chains and business activities are free from ethical and labour standards abuse.

As part of our commitment to eradicate modern slavery and human trafficking we will ensure that our:

- Due Diligence Process:

  - **Complies with legislation and regulatory requirements in this area**
    The Cabinet Office issued a directive on Modern Slavery in 2015, and Procurement has always referenced the legislation in our tender and contracting documentation. This was later followed with Cabinet Office Procurement Policy Notes - PPN 05_19 and more recently PPN02_23.

    The NHS Evergreen Sustainable Supplier Assessment, launched in June 2023 and embedded within Atamis, the NHS-wide e-commerce platform, enables NHS suppliers to share their progress against the NHS Net Zero Supplier Roadmap published in 2021. The Evergreen Assessment requires action on modern slavery to progress through the maturity levels of the assessment.

  - **Make suppliers and service providers aware that we promote the requirements of this legislation**
    Procurement makes suppliers aware of this legislation through the tender and contracting documentation we use when undertaking procurement tender exercises. We are reviewing the new guidance to cross-reference with our current processes and documentation. With regard to NHS terms and conditions these are 'owned' by NHS England so will reflect the new guidance with amendments made as required.

  - **Considers modern slavery factors when making procurement decisions**
    The shortlisting and selection process to identify suppliers to participate in a tender exercise includes Modern Slavery criteria. When accessing framework agreements this will be the same for the organisation that 'owns' the framework.

  - **Use NHS Terms and Conditions for Goods and Services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions**
    NHS terms and conditions are owned by NHS England and are updated accordingly.

- **Risk Assessment, Management and Effectiveness:**

  - **Encourages suppliers and contractors to take their own actions and understand their obligations under this legislation**
    Our tender documentation and contracts cover this, and evidence is requested in support of the criteria.

  - **Develops awareness of modern slavery issues throughout ESNEFT**
    Procurement staff complete government training via the Cabinet Office. This is currently being rolled out across the procurement team with six members already having received their certificates. Procurement attempts to promote the Modern Slavery Act by publishing the Procurement Policy Notes on the Procurement intranet page. In addition, the procurement quarterly newsletter is used to promote the Act to staff that frequently participate in tender and contracting projects and processes. It is proposed that for non-procurement staff the education team incorporate the theme into the ESNEFT Mandatory Training programme.

- **Ensures that procurement staff also receive regular legal briefings and appropriate training so that they are aware of legislative requirements in this area**
  Procurement staff receive regular briefings. This includes the Cabinet Office training and the training webinars that Mills and Reeve legal practice provides. This also forms part of the Chartered Institute of Purchasing and Supply (CIPS) qualifications

- **Policies in relation to modern slavery and human trafficking:**

  - **Ensure that all staff adhere to internal policies that support our commitment to eradicating modern slavery and are equipped to appropriately support when victims present. These include:**
    - Freedom to Speak Up policy
    - Safeguarding Adults policy
    - Safeguarding Referral Guide
    - Sexual Safety in Healthcare organisational charter
    - Safe Workplace – Tackling Sexual Harassment in the Workplace Guide
    - Equal Opportunities and Diversity Policy
    - Strategic Framework for NHS Commercial
    - NHS People Promise

- **Training**

  - **Ensure that modern slavery is included in safeguarding work plans**
    Included within Trust's Safeguarding Adults training and in some of our bespoke Safeguarding Children's training.

  - **Ensure that all staff undertake mandatory safeguarding training, and training in equality, diversity and human rights**
    All staff are subject to the mandatory training requirements of employment within the Trust and compliance is monitored at monthly divisional accountability framework meetings.

Approved by the Board of Directors on 1 May 2025

Council of Governors and our membership

The Council role

The Council of Governors represents the interests of the public, our staff and local organisations through its elected governors and appointed stakeholder governors. The Council has two general duties:

- To hold the non-executive directors to account, individually and collectively, for the performance of the Board of Directors; and
- To represent the interests of members as a whole and the interests of the public.

The other statutory duties of the Council are:

- The appointment and, if appropriate, removal of the chair and other non-executive directors – see the Remuneration Report
- Confirming the remuneration and allowances and other terms and conditions of office of the chair and the other non-executive directors – see Remuneration Report
- The approval of the appointment of the chief executive – not required this year
- The appointment and, if appropriate, removal of the auditor
- The receiving of the Trust's annual accounts, any report of the auditors on them and the annual report at a general meeting of the Council of Governors – received at the Annual Members' Meeting/Annual General Meeting held on 30 October in Clacton
- The approval of a significant transaction as defined in the Trust's constitution, or an application by the Trust to enter into a merger, acquisition, separation or dissolution – not required this year
- A decision on whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions – not required this year
- Approval of amendments to the Trust's constitution – approved 27 March 2025.

The Council is chaired by the chair of the Trust, supported by the Senior Independent Director, Director of Governance and Trust Secretary. This enables effective sharing of information between the Board and the Council.

The Trust Secretary is the first point of contact for governor support and queries, with the Chair and Senior Independent Director available as required. A Committee and Membership Secretary supports the Council and its committees.

The Council provides valuable insight from our staff and the community that we serve to support development of our future strategy. An email address - governors@esneft.nhs.uk - is in place enabling any member of the public to get in touch with governors. This is managed by the Trust's Secretary's office and, whilst it is not well used, it was felt important to retain it.

Formal Council meetings are scheduled at least four times each year, plus the Annual Members' Meeting/Annual General Meeting. Meetings alternate between a Colchester and Ipswich venue. The programme of meetings is confirmed for the next financial year to give all governors the opportunity to schedule these in advance to enable attendance and quorum to be met.

There are three Council committees: the Appointments and Performance Committee – details of which are contained within the Remuneration Report – the Standards Committee and Membership and Engagement Working Group. Terms of reference are reviewed and presented to Council for approval annually. All recommendations made by committees are presented to the Council for consideration and approval, as the Council is not able to delegate its powers.

A work programme supports the Council and its committees and is flexible to ensure that relevant items are presented at the right time. This continues to develop to respond to the Council's requirements. Council agendas are confirmed in discussion with the Chair, the Lead Governor and the Trust Secretary.

The Chief Executive or his deputy and the Director of Governance attend every meeting of the Council, together with non-executive directors. Executive directors are invited to attend, whilst in accordance with our Time Matters principles, they generally join for subject-specific presentations. This year these have included a presentation from the Trust's patient experience team, Making Time Matter: Driving Continuous Improvement at ESNEFT, updates on the Board's decision-making process in relation to soft facilities management services, a strategic update and Epic Electronic Patient Record, and the difference this will make to staff and to patients when it launches on 2 October 2025.

The Trust constitution

As mentioned earlier in this report, the Council considered and approved a revised constitution this year. Two amendments were subsequently approved by the Board on 3 April 2025:

- The definition and the value attributable to a significant transaction, increased to reflect the Trust's current £1.1bn annual turnover

- That the Public Constituencies are reduced from five to three, covering the following areas: the County of Essex, the County of Suffolk and All other areas of England.

An annual Board and Council lunch is scheduled to enable Board members and governors to spend some informal time together.

The Council has not exercised its power as stated in Schedule 7 of the NHS Act 2006 to require one or more of the directors to attend a governors' meeting.

Attendance at Council by Board members can be found here.

A Lead Governor, Helen Rose, was confirmed through an internal election process undertaken with the Council in early 2023. Helen works closely with the Chair and the Trust Secretary to ensure that the Council structure supports governors to undertake their statutory role and adds value. Helen also meets with the Senior Independent Director on a regular basis.

This year, a Deputy Lead Governor was elected, Caroline Bowden. Caroline will support Helen in the discharge of her duties as requested. In the event the Lead Governor is unavailable for a period, the Deputy Lead Governor would act as the designated point of contact between the Council of Governors and NHSE and would discharge the role of Acting Lead Governor.

Elections

The election process began in late 2023/24, with results confirmed at the Council of Governors on 20 June for a three-year term of office starting on 1 July. An independent provider, Civica Election Services Ltd, was appointed.

Governors hold office for a period of three years when they may be eligible for re-election or re-appointment as appropriate.

The Trust's constitution states that both elected and appointed governors may not hold office for more than three terms or a maximum of nine consecutive years. They are not eligible for re-election if that would result in them exceeding this time. This includes any period as a governor prior to ESNEFT being formed.

The next elections will take place during the summer/autumn of 2025.

Our governors

Membership of the Council during the year and attendance at meetings is included in the tables below. The Council at 31 March 2025 is as follows:

Public Governors (18)	
Colchester (4)	
Caroline Bowden*	Term 2 to 31 October 2025
David Guest	Term 1 to 30 June 2024; Term 2, 1 July 2024 to 30 June 2027
Jane Hadlow	Term 1, 1 July 2024 to 30 June 2027
Ben Paites	Term 1, 1 July 2024 to 30 June 2027
Rest of Essex (5)	
Tom Harrison	Term 1, 1 July 2024 to 30 June 2027
Martin Nixon*	Term 1, 1 November 2022 to 31 October 2025
Vacancy x3	

Public Governors (18)	
Ipswich (4)	
Paul Gaffney	Term 1, 1 July 2024 to 30 June 2027 (previously served)
Tim Newton*	Term 2, 1 November 2022 to 31 October 2025
Vacancy x2	
Rest of Suffolk (5)	
John Alborough**	Term 3, 1 November 2022 to 31 October 2025
Peter Coleman*	Term 1, 1 November 2022 to 31 October 2025
Verity Jolly	Term 1, 1 July 2024 to 30 June 2027
Gillian Orves**	Term 2 to 30 June 2024; Term 3, 1 July 2024 to 30 June 2027
Helen Rose** (Lead Governor)	Term 3, 1 November 2022 to 31 October 2025

Staff governors (7)	
ESNEFT	
Roger Blake	Term 1, 1 July 2024 to 30 June 2027
Isaac Ferneyhough**	Term 2 to 30 June 2024; Term 3, 1 July 2024 to 30 June 2027
Light Onyekachi	Term 1, 1 July 2024 to 30 June 2027
Andrew Taylor	Term 1, 1 July 2024 to 30 June 2027
Allison Weston**	Term 2 from 6 December 2022 to 30 June 2024 (took vacant post; also served to 31 October 2022) Term 3, 1 July 2024 to 30 June 2027
Colchester and Essex	Elected to this constituency pre staff constituency change 1/24
Pride Mukungurutse*	Term 2, 1 November 2022 to 31 October 2025
Ipswich and Suffolk	Elected to this constituency pre staff constituency change 1/24
Abhijit Bose*	Term 1, 1 November 2022 to 31 October 2025

*Seat to be vacated – governor can seek re-election
**Seat to be vacated – governor at term limit

Appointed governors (10)		
Councillor Sara Naylor	Colchester City Council Local Authority - Tendring District Council*	Colchester City Council 11 November 2024 to 10 November 2027
Councillor John Cook	Local Authority - Ipswich Borough Council* East Suffolk Council	Ipswich Borough Council 1 July 2024 to 30 June 2027
Councillor Lewis Barber	Partnership - Essex County Council	Term 1, 1 October 2024 to 30 September 2027
Rebecca Hopfensperger	Partnership - Suffolk County Council	Term 1, 1 July 2021 to 30 June 2024 Term 2, 1 July 2027 to 30 June 2027
Tracey Williams-Macklin Bradley Neal	Partnership University of Essex* Anglia Ruskin University	University of Essex - 1 October 2024 to 31 September 2027
Dr Jude Omniyi	Partnership - University of Suffolk	Term 1, 1 February 2024 to 31 January 2027
Karly Robbshaw, Colchester Group Practice	Partnership - Colchester Garrison	Karly Robbshaw Term 1, 14 October 2024 to 13 October 2027
Sam Glover	Partnership (one nomination) Healthwatch Essex	Term 1 to 30 June 2024 Term 2, 1 July 2027 to 30 June 2027
Jane Simpson Chief Executive, Anglia Care Trust	Integrated Care System Voluntary Community, Faith and Social Enterprise (VCFSE) Assembly (representing 130 organisations)	Term 1, 1 September 2024 to 31 August 2027
Vacancy	NEW: Organisation representing community diversity	

**depicts those organisations who share terms of office and alternate every three years*

Some of our long-serving governors left the Council on 30 June 2024:

- Public Governors James Chung, Alison Ruffell, Elizabeth Smith, Jane Young
- Staff Governor Gemma Bourne
- Councillor Gina Placey, Tendring District Council
- Mike Ninnmey, East Suffolk Council
- Carlo Guglielmi, Essex County Council, at the end of his third term
- Sara Smith, Anglia Ruskin University
- SSgt Daniel Tweed, Colchester Garrison, to 4 July 2024
- Public Governor Harry Shearing who, due to personal circumstances, was only able to serve on the Council for a short period post-election.

The requirements for attendance are included within the Council's Code of Conduct. A significant review of the Code has been undertaken this year, led by the Council's Standards Committee. A new Code was approved in December 2024.

Non-attendance is discussed with individual governors. Challenges with attendance have been raised with our appointed governors to seek to increase attendance, or should this not be possible, to seek an alternative nomination. Extenuating circumstances are considered.

Attendance of governors at formal Council meetings is set out overleaf.

Member/Attendee		20-Jun-24	26-Sep-24	31 OCT 24 PRIVATE	03-Dec-24	25 Feb 25 PRIVATE	27-Mar-25	Total
Abhijit Bose, Staff Governor, Ipswich		Apologies	No	No	No	Apologies	No	0/6
Caroline Bowden, Public Governor		Yes	Yes	Yes	Yes	Yes	Yes	6/6
Gemma Bourne, Staff Governor, Ipswich		No						0/1
James Chung, Public Governor, Rest of Essex		No						0/1
Peter Coleman, Public Governor Rest of Suffolk		No	Yes	No	Yes	No	Yes	3/6
John Cook, Appointed Governor, Ipswich Borough Council			No	No	No	Yes	Yes	2/5
Isaac Ferneyhough, Staff Governor, Colchester		Apologies	Yes	Yes	Yes	Yes	Yes	5/6
Paul Gaffney, Public Governor, Ipswich			Yes	Yes	Yes	Apologies	Yes	4/5
Sam Glover, Stakeholder Governor, Healthwatch Essex		Yes	Apologies	Yes	No	No	No	2/6
David Guest, Public Governor, Colchester		Yes	Yes	Apologies	Yes	No	Yes	4/6
Cllr Carlo Guglielmi, Stakeholder Governor, Essex County Council		Apologies						0/1
Jane Hadlow, Public Governor, Colchester			Yes	Apologies	Yes	Apologies	Yes	3/5
Tom Harrison, Public Governor, Colchester			No	No	No	No	Apologies	0/5
Rebecca Hopfensberger, Stakeholder Governor, Suffolk County Council		Yes	Yes	No	No	No	Apologies	2/6
Verity Jolly, Public Governor, Rest of Suffolk			Yes	Yes	Yes	Yes	Yes	5/5
Pride Mukungurutse, Colchester		Apologies	No	No	Yes	No	Yes	2/6
Sara Naylor, Appointed Governor, Colchester City Council					Yes	No	Yes	2/3
Bradley Neal, Joint Appointed Governor, University of Essex					No	Yes	Apologies	1/3
Tim Newton, Public Governor, Ipswich		Yes	No	Yes	Yes	Yes	Yes	5/6
Cllr Mike Ninnmey, Appointed Governor, East Suffolk Council		Apologies						0/1
Martin Nixon, Public Governor, Rest of Essex		Yes	Yes	Yes	Yes	Yes	Yes	6/6
Light Onyekachi, Staff Governor			Yes	Yes	Yes	Yes	Yes	5/5
Cllr Gina Placey, Stakeholder Governor, Tendring District Council		Apologies						0/1
Jude Ominyi, Stakeholder Governor, Univerty of Suffolk		Apologies	Apologies	No	Apologies	No	Apologies	0/6
Gillian Orves, Public Governor, Rest of Suffolk		Apologies	Apologies	No	Apologies	No	Yes	1/6
Karly Robbshaw, Appointed Governor, Colchester Garrison				Yes	No	No	No	1/4
Alison Ruffell, Public Governor, Colchester		Apologies						0/1
Jane Simpson, Appointed Governor, Integrated Care System Voluntary Community, Faith and Social Enterprise Assembly			Yes	Yes	Apologies	Apologies	Yes	3/5
Elizabeth Smith, Public Governor, Rest of Essex		Yes						1/1
Sara Smith, Stakeholder Governor, Anglia Ruskin University		Apologies						0/1
Andrew Taylor, Staff Governor			Yes	No	Apologies	No	No	1/5
Daniel Tweed, Stakeholder Governor, Garrison		Apologies						0/1
Allison Weston, Staff Governor, Ipswich		Yes	Yes	Apologies	Yes	Apologies	Yes	4/6
Tracey Williams-Macklin, Joint Appointed Governor, University of Essex					Apologies	No	Apologies	0/3
Jane Young, Public Governor, Rest of Essex		No						0/1

The support provided to governors

The Trust's induction process for new governors continues to develop. This starts as soon as the election results are available. New governors receive a welcome letter from the Trust Chair and a meeting is arranged with the Trust Secretary. This enables a new governor to talk about their experience, their interests, the time they have available and their expectations for this important, voluntary role.

This year significant work was undertaken to provide a full induction document which was discussed at the induction day held on 9 July. Existing governors are encouraged to attend to enable governors to start to build relationships. The induction included a risk assessment to ensure that health and safety requirements were met whilst governors are attending Trust sites, notification of any declarations of interests – included in all Council meeting papers to ensure transparency – an overview of individuals' preferences and time commitment, and acceptance of the Council's Code of Conduct.

At the induction event, governors received an overview of the role of the Board and the Council, the Trust's approach to equality, diversity and inclusion and information governance training, essential elements in this first session. Governors were also able to meet the Chief Executive and the Director of Governance.

A full schedule of development includes regularly briefing sessions and a six monthly development day, held on 12 February 2025. The issues covered have included:

- Our business plan and significant transactions
- Patient care and safety - the fundamentals of care
- Maximising resources and the Accountability Framework
- What does Governance mean at ESNEFT and how do governors help to support good governance
- PLACE visits – Patient-Led Assessment of the Care Environment
- Membership and engagement
- The External Auditors – their role
- Seasonal resilience planning
- The work of the Trust Charity – delayed until early 2025/26.

Governors have also undertaken visits with non-executive directors, and have viewed new facilities including ESEOC, the UTC at Ipswich Hospital, and have been offered the opportunity to get involved in food tasting.

Governors are encouraged to join meetings of the Board of Directors in public, with attendance beneficial at least annually in a governor's first 12 months in office. The link to the meeting papers is sent to all governors as soon as these are published on the Trust website and several governors have attended meetings this year.

A programme of 15 steps visits was previously in place when governors join non-executive directors on visits across Trust services. This has been an excellent opportunity for individual governors to engage with our non-executive directors. Governors have also previously participated in PLACE visits, with plans for this to be reinstated. In addition to this formal framework, reports on governors' activities are received at every Council meeting.

Governors are expected to meet the Trust's values. Signing up to the Council's Code of Conduct is a requirement for all members of the Council. Any breaches would be investigated through the Council's Standards Committee. Following the revisions made to the Code, governors were asked to re-confirm their adherence to its requirements.

One of the ways in which governors undertaken their general duty to hold the non-executive directors to account for the performance of the Board, is by observing Board Assurance Committees. This has worked very well, enabling up to two governors to be in attendance to listen to the discussion, and to feed back to the Council. This year governors have continued to attend the:

- Audit and Risk Committee
- Charitable Funds Committee
- People and Organisational Development Committee
- Performance and Finance Committee
- Quality and Patient Safety Committee.

Our membership engagement

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

The Trust's membership database is managed by an external company who undertake regular checks of members, advising of those that are due to be removed. This is supported by the Committee and Membership Secretary. At 31 March 2025, ESNEFT had 9,833 public members (2023/24: 9,910) and 11,037 staff members (2023/24 11,555).

Category or Constituency	Active	Inactive	Suspended	Total
Public Constituencies	**9832**	**0**	**1**	**9833**
Out of Trust Area	37	0	0	37
Colchester	2415	0	0	2415
Ipswich	2055	0	1	2056
Rest of Essex	2426	0	0	2426
Rest of Suffolk and South Norfolk	2899	0	0	2899

The Council's work on membership is undertaken through the membership and engagement working group – chaired by a public governor. This was previously open to all governors; attendance was not consistent and this had a negative effect on the progress being made.

As part of the annual review of effectiveness this issue was considered with governors during the summer, including the governor Chair of the working group and the Lead Governor and it was confirmed that membership would be formalised. It was positive that governors wished to attend these meetings, and they are still welcome through a request to the working group chair. However, more progress has been made in the latter half of the year in delivering the membership plan:

- A Council ‘pop up’ and display boards have been purchased to enable governor engagement. A stand was included at the Annual Members’ Meeting in Clacton, supported by staff governor Allison Weston.
- The Lead Governor is progressing discussions on the support required for governors to engage in their communities, with some informal meetings having taken place. This was considered further at the six monthly development day in February.
- Governors were in the Colchester Hospital foyer on 2 December and Ipswich Hospital on 9 December to support engagement on It’s Ok to Ask, talking with visitors and patients to find out their thoughts. This considered how we support patients to fully understand their condition and make sure they have all the information they need during discussions about their care. A QR code and hard copy surveys were used.
- A questionnaire was circulated to all governors to underpin future newsletter content for the Get Involved e-newsletter and the Trust’s ESNEFT Life magazine – the winter edition included a focus on our Lead Governor.
- Staff governors are working together to represent staff, and two staff governors attend the working group.
- Health talks are being arranged, with the first scheduled for early in 2025/26 on diabetes care.
- Governors will be joining ESNEFT staff at the Trust’s stand at the Suffolk Show and the Tendring Show, to talk to local people about their role.

A quarterly briefing is in place, prepared by the communications and engagement team following discussion at the working group, for circulation to Council. This supports key messaging as governors engage with staff and local people.

Lead Governor’s reflections

As Lead Governor of this Trust’s Council of Governors, I can assure the users and potential users of ESNEFT’s services that, through the statutory powers given to our Council and through t

he additional opportunities given to us by this Trust, we’re always ready to make time to listen to people in the constituencies we represent, whether this be in East Suffolk or North Essex or as Staff Governors based in our hospitals or out in community services.

Apart from appointing the Trust’s Chair, the non-executive directors and the external auditors, we observe the Trust’s Board meetings and other assurance committees to monitor whether the non-executive directors are holding the executives to account.

During the period that this annual report covers, members of our Governors’ Appointments and Performance Committee have been involved in both the long and short listing of candidates for interviews for non-executive positions and latterly for that of Chair. Helen Taylor reached

the end of her final term of office on 31 March 2025 and we welcomed Deputy Chair Mark Millar as our interim Chair.

I worked with the Trust's Senior Independent Director for Helen Taylor's final appraisal as Chair, ensuring that all Governors had an opportunity to feed into this process.

Our Council of Governors has met four times during 2024/25, which included sessions both in public and in private. We were pleased to be able to hold our Annual Members' Meeting in Clacton on 30th October 2024, reporting on the year April 2023/24. It was a pleasure to be able to engage with so many local people at this event.

With Governor elections due in the latter part of 2025, Governors met to discuss the constituencies we represent and it was agreed and ratified by our Council of Governors that there would be an Essex constituency and a Suffolk constituency going forward. This will be rather than dividing these as Rest of Suffolk and Ipswich and Rest of Essex and Colchester constituencies.

The Trust supports Governors, both with ongoing training and with presentations to enhance our understanding of the complexity of the organisation. We have particularly appreciated an audit presentation from the Director of Finance. We have also been able to have a joint presentation with the Governors of West Suffolk Hospital.

In September, Governors were able to tour the new Urgent Treatment Centre at Ipswich Hospital prior to it being opened for patients. And in November I was able to tour the new state of the art Orthopaedic Centre at Colchester Hospital, The Dame Clare Marx Centre, with the patients' group that had been consulted at every stage of its design.

It has been an honour to be invited to share in Staff Awards events which have celebrated both long service at the Trust and special achievements within the many departments that ESNEFT supports.

I have been in touch regularly with the Director of Governance and his team and value their support. I have also appreciated being able to share day to day Governor matters with Caroline Bowden, the Deputy Lead Governor.

Governors are your voice within ESNEFT and you can contact us via governors@esneft.nhs.uk or go to the Trust's website to find out more about us - https:www.esneft.nhs.uk>about-us

Helen Rose
Lead Governor

Statement of accounting officer's responsibilities

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

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

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

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

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

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

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

Nick Hulme
Chief Executive
26 June 2025

Annual Governance Statement

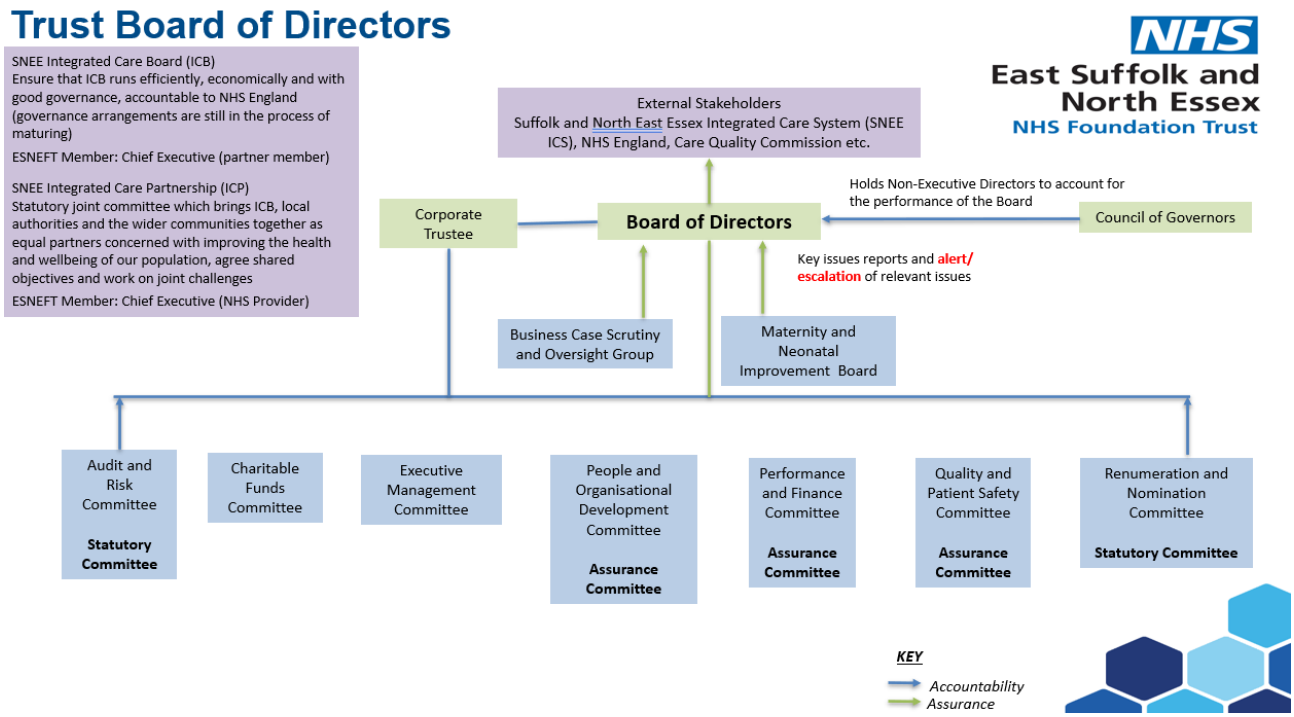
Scope of responsibility
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible,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

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore 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 achievement of the policies, aims and objectives of East Suffolk and North Essex NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East Suffolk and North Essex NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
As Accountable Officer, I have overall responsibility for ensuring there are effective risk management systems and controls in place within the Trust, for meeting all statutory requirements, and adhering to guidance issued by NHS England in respect of governance and risk management. The Trust is committed to the principles of good governance and understands the importance of effective risk management as a fundamental element of its governance framework and system of internal control.

The Board of Directors (the Board) provides overall leadership on the governance agenda, including risk management. It is supported in this area through the work of its committees, in particular by:

- The Audit and Risk Committee, and the internal audit service, in assessing the effectiveness of the Trust's systems of internal control
- The Quality and Patient Safety Committee in assessing the assurance available through the systems for ensuring the clinical quality of the services provided by the Trust
- The Executive Management Committee, the senior management-level decision making group in the Trust with clinical and operational oversight of performance, advising the Board, Board committees and Executive Directors as required,
- The work of all Board committees in reviewing and monitoring key strategic risks recognised on the Board Assurance Framework (BAF), as delegated by the Board.



Committee effectiveness is reviewed annually in accordance with the requirements of the Code of Governance for NHS provider trusts. The outcome is presented to the Board for approval, together with any proposed amendments to Terms of Reference and committee membership and non-executive director lead responsibilities.

The Board routinely receives reports from its committees which highlight the key areas of discussion and items escalated for the attention of the Board. The Board also regularly reviews areas of key strategic risk through the BAF, supported by detailed work undertaken by relevant Board committees. The strategic risks contained within the BAF are aligned to the Board, the Performance and Finance Committee, the People and Organisational Development Committee or the Quality and Patient Safety Committee. The Audit and Risk Committee considers the full BAF at every meeting, including a summary of the discussions held at the relevant Board committees. An additional strategic risk was developed in early 2025 relating to digital resilience and is to be aligned to the Audit and Risk Committee which retains oversight for cyber security and controls.

The expectation is that all risk management activities follow the process set out in the risk management policy to ensure a common approach is adopted. Risk management is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and an employer of significant numbers of staff. The policy supports the Board to demonstrate that it has been properly informed, through evidence from the BAF and Corporate Risk Register, that it is aware of the totality of the risks facing the organisation. The Corporate Risk Register (CRR) provides the organisation with a simple but comprehensive method of risk assessment and management to meet the Trust's corporate objectives. The Risk Oversight Committee (ROC) considers entries in the risk registers and validates the Corporate Risk Register, reporting to the Audit and Risk Committee and the Executive Management Committee.

Responsibility for the identification, management and mitigation of risk is identified clearly across the Trust. The Chief Executive is supported by members of the Executive Team who have responsibility for ensuring effective risk management across their portfolios. The day-to-day responsibility for ensuring efficient and effective risk management within the Trust has been delegated to the Director of Governance, who is responsible for the implementation of the risk management policy.

All heads of service, clinical directors and managers have delegated responsibility for the management of risk and patient safety in their areas, as integral to their day-to-day responsibilities. Each division has a risk register, which aligns with the Trust's risk register requirements, in accordance with the risk management policy.

The reporting of incidents is encouraged. All members of staff are required to comply with the Trust's policies and procedures and have responsibility for the management of risk through identifying and reporting risks, incidents and 'near-misses', and contributing to their effective management and mitigation.

The Trust recognises the importance of supporting staff through appropriate training, development and access to systems, and the governance and patient safety teams provide support to staff who are undertaking risk assessments and managing risk as part of their role. Appropriate risk assessment training is provided to all members of staff, including:

- Mandatory and role essential training for staff at specified intervals as part of our work to deliver safe care
- Targeted training in specific divisional areas including risk assessment and incident reporting
- Incident investigation training to support colleagues reviewing and learning from incidents
- Training and mentoring support for the electronic adverse event reporting system that is targeted at managers of wards, departments and non-clinical areas
- A proactive approach is taken to identify risks to safe care which includes human factors as an essential part of patient safety training, pivotal in achieving optimal patient outcomes. A new model of training has been developed in the second half of the year to replace the previous full day classroom session with a one day masterclass, team training and an e-learning module, to provide a sustainable approach for the future.

The Trust has a defined mandatory, statutory and role essential training policy, which sets out minimum requirements to ensure that all staff have received the appropriate training relevant to their roles and responsibilities. This is renewed at appropriate intervals. A detailed workforce report is presented to the Executive Management Committee and the People and Organisational Development Committee, detailing the competencies required and compliance levels.

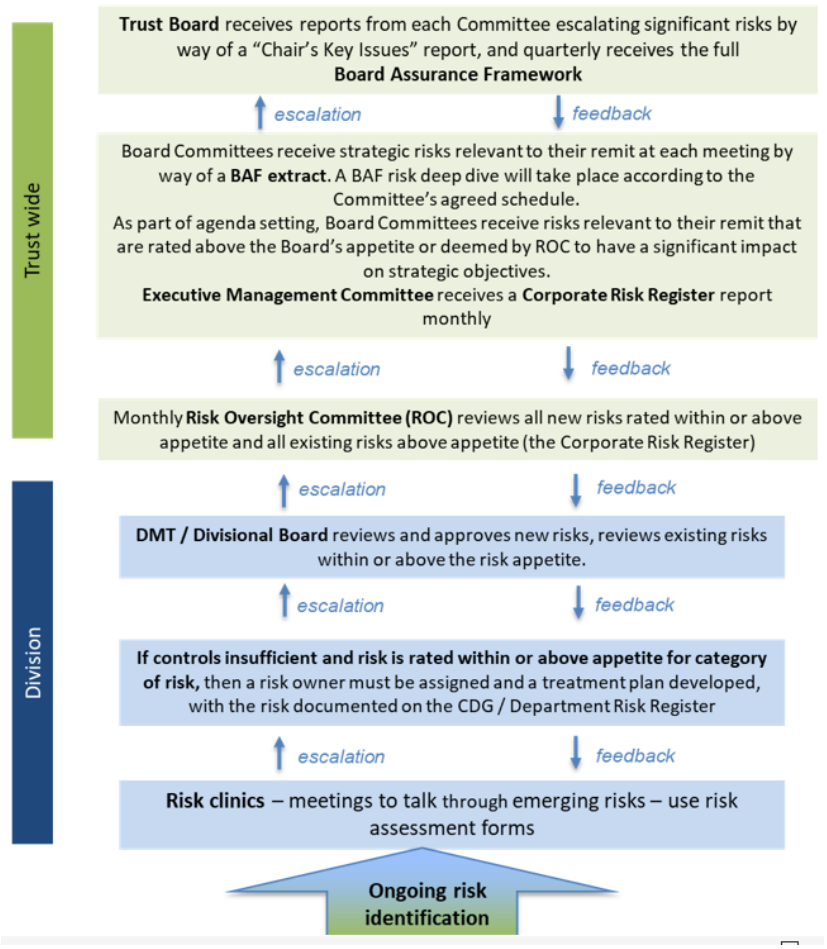
During the year ended 31 March 2025, the Trust achieved a level of 93.8% compliance by staff colleagues against the requirements.

Learning from incidents and 'near-misses' ensures that opportunities to improve are identified and opportunities for error are reduced. Incidents, complaints and patient feedback are routinely analysed to identify learning opportunities. The Quality and Patient Safety Committee has oversight and assesses the assurance to be provided to the Board that the Trust is effectively learning from experience. This includes a regular review of the quality programme and priorities, clinical outcomes and quality improvement, emerging and urgent issues and the mitigation in place and further action planned. Learning identified is disseminated to colleagues at all levels, through a variety of methods as appropriate to local circumstances.

The risk and control framework

The Board has adopted a risk management policy, reserved to the Board for approval, reviewed regularly with the advice of the Audit and Risk Committee. It sets out a consistent, clear approach to the assessment of risk, based on a five-by-five matrix to evaluate both the likelihood of a risk happening and the impact if it does, which is utilised for all risks. A revised approach to how risk appetite operates, and a revised policy was approved in December 2024.

The flowchart below provides an overview of the risk identification, approval and monitoring process.



The policy sets out the key responsibilities and procedures for the management and mitigation of risk throughout the Trust:

Non-Executive Directors. The Trust Board committees are chaired by non-executive directors. They are accountable to the Trust Board through the Chair. They play an essential role in ensuring that the Trust's governance and risk arrangements are robust and effective.

Chief Medical Officer and Chief Nurse. The Chief Medical Officer and Chief Nurse provide clinical leadership and scrutiny for quality (patient safety, clinical effectiveness and experience) and clinical risk. They work closely with the Director of Governance who leads on corporate governance, compliance and risk systems/processes. Other areas are delegated as detailed below:

The Executive and Non-Voting Directors: All Directors of the Trust are accountable to the Chief Executive and have responsibility for the management of risk within their individual portfolios (including maintenance of portfolio risk registers), for contributing to the construction and on-going review of the BAF, and the implementation of resulting action plans. The fundamental role of the Directors is to provide leadership by ensuring that the plans for the management of risks for which they are responsible are continuously developed and communicated across the organisation.

The Chief Medical Officer or Chief Nurse are members of all key governance committees.

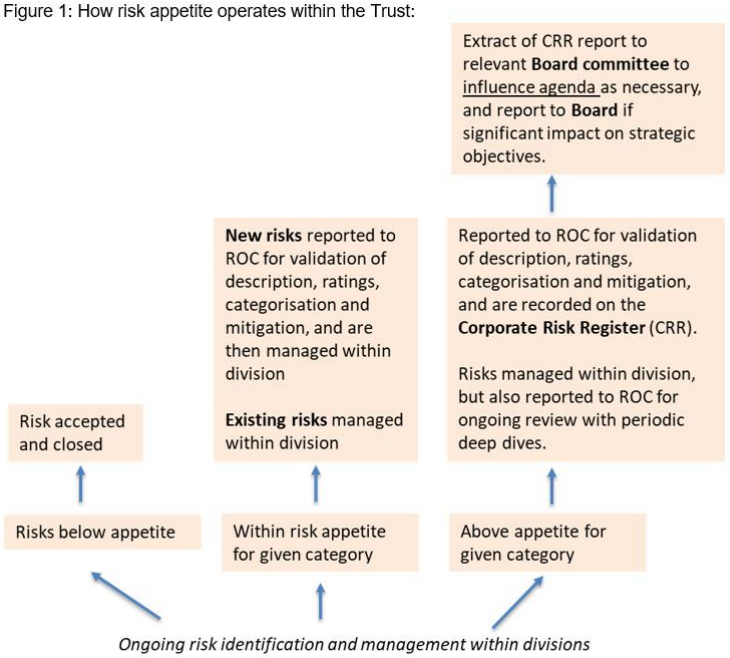
Various aspects of risk management are delegated to executive leadership, and this is described within the policy.

The broad categories of risk faced by the Trust include:

- **Strategic risk** – associated with the Trust's ability to maintain its longer-term viability and the delivery of national and local priorities
- **Performance risk** – the ability of the Trust to deliver high quality care for patients in accordance with the Trust's business plan and the standards set by the Care Quality Commission and NHS England
- **Financial risk** – that a weakness in financial control could result in a failure to safeguard assets, impacting adversely on the Trust's financial viability and capability to provide services
- **Reputational risk** – that the organisation receives negative publicity, which impacts on public confidence in the organisation
- **Operational risk** – that threatens the day-to-day delivery of clinical care and services
- **Clinical Practice Risk** - to individual patients relating to their clinical care and treatment. The risks will start on admission and continue throughout the patient's episode of care. Assessment of risks and the process for documenting the outcome of any risk assessment is set out in clinical policies and guidelines.

The revised approach to risk appetite is as described at figure 1:

Figure 1: How risk appetite operates within the Trust:



Risks rated below the appetite are accepted and closed. Risks rated within appetite are reported to ROC and then managed within the division. Risks rated above the appetite are added to the Corporate Risk Register (CRR) and routinely reported to ROC, with summary reporting to Board Committees and to the Board if a significant impact on strategic objectives is identified. It is for the ownership manager to advise on tolerating, reducing, transferring or eliminating the risk.

The risk appetite statements are as follows:

Financial /VfM impact

Appetite sub-category:	Appetite Statement:	Appetite:
Financial Sustainability of services CIP Development VfM (including performance)	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Cautious: accept risks rated below 6 manage risks rated 6 to 10 escalate** risks rated 12+
Business Growth	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Flexible accept risks rated below 12 manage risks rated 12 to 15 escalate** risks rated 16+

Compliance and Regulatory impact

Appetite sub-category:	Appetite Statement:	Appetite:
NHS legislation CQC regulatory compliance Employment law Data protection Health and safety	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Cautious: accept risks rated below 6 manage risks rated 6 to 10 escalate** risks rated 12+

Quality and Safety impact

Appetite sub-category:	Appetite Statement:	Appetite:
Patient Safety	Tolerance for risk taking limited to decisions where the potential for consequent effects on patient safety, experience or outcomes are moderate, although prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigating actions are strong.	Minimal to cautious: accept risks rated below 2 manage risks rated 2 to 10 escalate** risks rated 12+
Patient Experience QI faculty User involvement	Prepared to put quality at risk and accept the possibility of uncertain outcomes if other benefits may materialise.	Flexible: accept risks rated below 12 manage risks rated 12 to 15 escalate** risks rated 16+
Clinical outcomes	Prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigating actions are strong.	Cautious accept risks rated below 6 manage risks rated 6 to 10 escalate** risks rated 12+

Reputation impact

Appetite sub-category:	Appetite Statement:	Appetite:
Internet and social media	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Open accept risks rated below 12 manage risks rated 12 to 16 escalate** risks rated 20+
Public and membership engagement		
Stakeholder engagement		
Staff engagement	Appetite to take decisions with potential to expose the organisation to additional scrutiny/ interest. Prospective management of organisation's reputation.	Flexible accept risks rated below 12 manage risks rated 12 to 15 escalate** risks rated 16+
Consultation on service change		

Workforce impact

Appetite sub-category:	Appetite Statement:	Appetite:
Organisational culture	Prepared to take decisions that would have a negative impact on staff morale if there are compelling arguments supporting change.	Flexible accept risks rated below 12 manage risks rated 12 to 15 escalate* risks rated 16+
Leadership & talent management		
Recruitment and Retention		
Education and Training		

An equality impact assessment is embedded in the process for preparation of Trust policies. A Standard Operating Procedure is in place for the Board and its Committees including a covering report to Board and Committee papers with an executive summary to link to the relevant strategic objective, legal, regulatory and audit matters and BAF risk.

The principal risks to the achievement of the strategic objectives that the Board has agreed are recorded within the BAF. An Executive lead is identified for each strategic risk, and each is aligned to a Board committee or retained by the Board. Each risk details the key controls and mitigations in place to manage the risk. Evidence, both positive and negative, is recorded regarding the effectiveness of controls, and any gaps in controls and assurance are identified and the actions planned to improve.

The BAF is reviewed three times a year by the Board in public, supported by the work of Board committees to whom the detailed oversight of specific risks has been delegated. The Associate Director of Governance meets with the Executive lead monthly to update the BAF prior to presentation to the relevant committee, and this steers the work of the committees in seeking additional assurance as deemed necessary.

The current risks recorded on the BAF are:

1. Partnership working – reserved to the Board
2. Financial performance and sustainability, failure to maintain revenue financial balance in future years – Performance and Finance Committee
3. Insufficient capital resources to progress investments – Performance and Finance Committee
4. Quality assurance mechanisms regarding the quality and safety of patient services – Quality and Patient Safety Committee
5. Workforce, recruitment and retention – People and Organisational Development Committee
6. Sustainable delivery of elective performance targets – Performance and Finance Committee

6A. Sustainable delivery of emergency care performance targets – Performance and Finance Committee

6B. Timely cancer diagnosis and treatment – Performance and Finance Committee

7. Estates development and capital equipment – Performance and Finance Committee

8. Improvements to patient quality, safety and experience through implementation of an EPR (Electronic Patient Record) – Quality and Patient Safety Committee
9. Transformation – reserved to the Board.

BAF10 digital resilience, will be presented to the Board on 1 May 2025 for approval.

All NHS foundation trusts and NHS trusts are required to hold a Provider Licence, which sets out the conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. The Trust's declaration of compliance was considered by the Quality and Patient Safety Committee and the Audit and Risk Committee. The outcome for 2024/25 was confirmed by the Board in on 1 May 2025.

Quality governance

Quality governance arrangements are led by the Chief Medical Officer and Chief Nurse, with oversight by the Board, the Quality and Patient Safety Committee and the Executive Management Committee. This provides robust governance to deliver effective oversight to ensure the Trust is operating in the best interest of patients.

The committees are supported by three key executive-level groups: the Patient Safety Group, the Clinical Effectiveness Group, and the Patient Experience, Co-Production and Carers Council. The latter replaced the Patient Experience Group this year, to give an effective voice to carers, to provide and review feedback on Trust services to help develop improvement strategies to increase the quality and consistency of patient, carer and staff experience, and to contribute to Trust documents and programmes of work. Each group has representation from the divisions and provides reports directly to the Quality and Patient Safety Committee and the Executive Management Committee.

Our Quality Strategy supports the delivery of the Clinical Strategy, focusing on the principles of quality care, of which learning lessons and making improvements is key. The Trust was an early adopter of the Patient Safety Incident Response Framework and through the Patient Safety Incident Response Plan trends and themes are reviewed to identify emerging risks to prioritise the areas requiring deeper investigation. Patient safety incidents are discussed at the Patient Safety Oversight Panel, chaired by the Chief Medical Officer. The number of patient safety incident investigations and patient safety reviews is considered for assurance at the Quality and Patient Safety Committee.

Patient Safety Partners are actively involved in the design of safer healthcare at all levels in the organisation. This includes roles in safety governance to support compliance monitoring and how safety issues should be addressed, providing appropriate challenge to ensure learning and change and involvement in the development and implementation of relevant strategies and policies. Two part-time partners, with lived experience of using NHS healthcare services and an understanding of and broad interest in patient safety, were externally recruited and joined the Trust in November 2024. They attend the Quality and Patient Safety Committee and participate in the discussion. From 2025/26, they will report six monthly and provide an update to the Board in early 2026 describing the impact of their work.

At a divisional level, there are arrangements in place to ensure that the divisions have appropriate quality governance throughout their operations, under the leadership of the divisional management team. This year a review of Trust meetings and decision-making has taken place with the aim of streamlining governance, enhancing effectiveness and minimising duplication to support engagement with large strategic projects, including the implementation of the Epic Electronic Patient Record system. Further work is underway in early 2025/26 to enable further consistency of reporting as the new divisional structure is implemented from 1 April 2025.

The Accrediting Care at ESNEFT programme, ACE, provides the tools to undertake a comprehensive assessment of quality of care at ward, unit and team level, with a focus on the fundamentals of care. The programme brings together key measures into a single, overarching framework, from across nursing and clinical care, as relevant to us and to our patients. As this programme has developed, the Quality and Patient Safety Committee has received regular updates, and a presentation was received at the Board in public in November 2024. Progress and ratings are now included in the integrated performance report and the learning underpins future improvement priorities.

A robust process is in place to support maternity and neonatal services. The Maternity and Neonatal Improvement Board reports direct to Board. The service has made significant progress since entering the national Maternity Safety Support Programme in June 2021 provided mandated support. Confirmation has been received that the Trust has moved to the sustainability phase with the ambition of exiting the process by summer 2025.

The Quality Improvement (QI) and Clinical Outcome teams sit within the corporate division, nursing and quality. 2024/25 is the first year that the clinical outcome team, previously the clinical audit team, has been brought together with the QI team to align improvement with audit outcomes to streamline the improvement journey for divisions. This a central resource to support staff using a systematic method, involving those closest to the quality issue in discovering solutions. The service aligns with NHS Impact and focusses on building improvement capability and capacity through a training and coaching support offer.

The Trust has continued to participate in a programme of clinical audit work, in accordance with national requirements. A review was conducted of outstanding national/NICE and priority audits from 2023/24, and divisions assessed the risk of any audits not completed. Audit and QI plans for 2024/25 were confirmed across most divisions. 65 priority audits have been completed and over 200 unplanned audits. The Quality and Patient Safety Committee considers a detailed report three times each year and will be updated on the 35 audits planned which were not completed. An internal audit review has also been undertaken, with further details below.

A revised approach to assessing clinical outcomes was presented to the Board in January 2025 to enable the assessment of measurable changes in health, function or quality of life that result from the care provided to patients. A programme of work will support each service to confirm the key outcomes, to benchmark against and to be available to patients and users. A challenging timetable was described to ensure readiness for Epic implementation and a toolkit for services by December 2025. This will be reported through the Trust’s governance processes to the Quality and Patient Safety Committee.

A new Reflective Learning Forum is in place, meeting quarterly to actively support an open culture of learning. Themes and areas for action from the committees and groups mentioned, and our divisional accountability meetings, are discussed. A learning showcase from clinical divisions is also provided. Presentations to date have included case studies from:

- North East Essex Community Services
- Cancer and Diagnostics
- Surgery, Gastroenterology and Anaesthetics
- Employee relations
- Integrated Pathways Community Services
- Medicine Colchester.

The Trust engages with public stakeholders in a number of ways regarding risks that affect them. As part of the SNEE ICS and its place-based Alliances structure, we engage with partner organisations across all sectors in the system to collaboratively address shared risks. These include:

- the transfer of individuals across health and social care boundaries and the seamless management and support of patients across all providers
- the demand for emergency care services and preventing attendance and admission to hospital where appropriate
- the use of virtual wards and providing care closer to home
- reducing health inequalities and seeking to improve individuals' conditions to prevent more serious treatment becoming necessary, thereby addressing the wider determinants of health that will impact on individuals across the area of the ICS
- support for patients with complex mental health needs
- children and young people's services
- declining productivity and financial sustainability
- recruitment and retention of staff.

The Board regularly hears directly from patients, carers and staff which enables triangulation with the other information provided. A programme of visits to Trust services is also in place. The Council of Governors, comprising governors elected by staff and public members, and those appointed by a range of stakeholder organisations, provides the views from members and the wider public on the services that the Trust provides. Members of the Council participate in Trust visits and are scheduled to provide further support to PLACE inspections.

Full details of the arrangements for quality governance, including metrics on performance, clinical audits and plans to further develop and improve, can be found in the annual Quality Account that will be published by the Trust in accordance with statutory requirements.

Regulatory Compliance

As an organisation registered with the Care Quality Commission, the Board recognises its responsibility to be assured that the Trust is maintaining compliance with the requirements set out in the Health and Social Care Act 2012 (Regulated Activities) Regulations 2014, as amended. The Board, through the Quality and Patient Safety Committee, regularly reviews the assurance available regarding compliance with the requirements. This work is supported through the three clinical governance groups – the Clinical Effectiveness Group, the Patient Experience, Co-production and Carers' Council and the Patient Safety Group.

The Committee considers an Integrated Patient Safety and Experience Report at each meeting and an update on external visits six monthly and the status of actions arising from these. All registered providers must have an accurate, up-to-date statement of purpose which describes the organisation, and the services provided. A full review was undertaken this year with input from clinical divisions and following the advice of the CQC to ensure the guidelines and legislation are interpreted consistently and proportionately. The revised statement was approved by the Quality and Patient Safety Committee on 24 October 2024, for annual review.

During the year, 68 regulatory or compliance visits took place. These included:

- An announced Health and Safety Executive (HSE) site visit to Colchester and Ipswich Hospitals on 9, 10 and 11 April 2024 to assess the management arrangements for Violence and Aggression and Musculoskeletal Disorders (MSDs). Contraventions of health and safety law were identified, and a Notification of Contravention was received regarding the management of violence and aggression. The Trust responded in full, and the HSE confirmed that the action taken demonstrated the commitment of the Trust to address the issues raised and the intervention was closed.

- An announced HSE inspection of the Containment Level 3 (CL3) laboratory at both Colchester and Ipswich Hospitals during July 2024. A breach of regulation 13(1) of COSHH relating to emergency response arrangements was identified. The Trust completed the required actions and submitted evidence to the HSE who were satisfied the issue was addressed.

- Three visits relating to compliance with the Regulatory Reform Fire Safety Order 2005.

- The Care Quality Commission (CQC) has conducted the following inspections of specific services provided by the Trust:

    - An announced Ionising Radiation (Medical Exposure) Regulations inspection of Ipswich Hospital was completed on 1 August 2024

    - An announced IR(ME)R Inspection, Radiotherapy, Colchester Hospital, 27 November 2024

    - In the early part of 2025/26, on 9 and 10 April 2025, the CQC made an unannounced inspection of medical care (including older people services) at Colchester Hospital. The CQC also made an unannounced inspection of urgent and emergency care at Colchester Hospital on 29 and 30 April 2025.

Workforce strategies

The Board approved a revised People Strategy in November 2024. This sets out the strategic objectives including ensuring the right number of staff in the right place at the right time with the right skills. Metrics are reviewed by the Board through the Integrated Performance Report, supported by the detailed work undertaken by the People and Organisational Development Committee and the Quality and Patient Safety Committee.

In October 2018, NHS Improvement launched a Workforce Safeguards toolkit to direct Trusts to ensure that there are appropriate safeguards in place that support NHS boards to make informed, safe and sustainable workforce decisions. Further information can be found at this link.

In January 2025, the Chief Medical Officer, Chief Nurse and Director of People and Organisational Development presented an assessment of compliance against the workforce safeguards toolkit to the People and Organisational Development Committee. This demonstrated continued progress to triangulate all the data available, supporting a clearer view on determining whether all aspects of the workforce are achieving maximum productivity and efficiency. Throughout the previous six months there had been challenges in relation to industrial action that had impacted on many staff groups. There had been progress with roll out of medirota, improved processes and governance around booking of bank staff and a continued focus on multidisciplinary working and training. There was more to do to triangulate vacancies, with care hours per patient day, safe care and other data, and evaluation of the roll out of self-roster. The report was recommended to the Board and the Executive Team's assessment of assurance against the indicators was confirmed, with continued delegation of ongoing monitoring to the People and Organisational Development Committee. Relevant items would be escalated to the Board as required.

NHS Provider Boards are required to ensure there is sufficient and sustainable nurse and midwifery staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings and that an annual strategic staffing review takes place. Operationally, staff numbers are reviewed regularly during the day and action is taken to address any areas where there are potential difficulties, through the movement of staff.

In April 2024 the Board received the final report following the annual comprehensive establishment and skill mix review undertaken during 2023/24. During the summer of 2024, a new Chief Nurse joined the Trust, and a triangulated approach was taken to inform any recommendations. This considered patient acuity and dependency, nurse sensitive indicators, roster data and professional judgement. The outcome was considered by the People and Organisational Development Committee and the Executive Management Committee. For midwifery, a comprehensive Birth Rate+ review is required every three years, and this was completed in 2023. The report described the annual review, the detail of which had previously been presented to the Board as part of reporting to meet the Clinical Negligence Standards for Trusts (CNST) Maternity Incentive Scheme.

The skill mix review provided recommendations and indicated there were a small number of clinical areas that required adjustment to the funded establishment. The Board, at its meeting on 3 April 2025, approved the outcome and supported the recommended actions to optimise achievement of the right staff with the right skills in the right place.

In accordance with the NHS 2024/25 priorities and operational guidance, productivity has been considered during the year. Significant work was undertaken to understand the Trust's productivity metrics, to identify the productivity gap and the opportunities to improve. This was considered by the Performance and Finance Committee and the Executive Management Committee and underpinned Trust planning for 2025/26. The People and Organisational Development Committee reviewed this from a workforce perspective and the relationship between productivity, changes to skills, and Epic implementation. A new process is being implemented in 2025/26 to support delivery of the Trust's plan and to accelerate the delivery of best practice and the best clinical outcomes. This will support the eradication of non value added work, reduce duplication and waste, improve outcomes and release time to care.

Well-led

The Trust's CQC rating for well-led is Good following inspection in June/July 2019 and publication of the final report on 8 January 2020. An external review of the Trust's governance was undertaken in 2022 by Deloitte, reporting in December 2022. The implementation plan was approved by the Board in May 2023 and an update was reported to the Board in November 2023 confirming completion. Planning during 2025/26 will enable a further external review to take place in early 2026/27.

The Accountability Framework Policy, implementation of the framework and divisional accountability meetings assess the performance of all divisions against the six domains, caring, responsive, safe, effective and well-led, to provide an aggregate score. This is considered by the Executive Management Committee and is provided for assurance to the Performance and Finance Committee monthly. Divisional accountability meetings are held monthly where compliance against internal control arrangements is carried out through a monitoring of performance across a range of areas, and by looking at a number of relevant indicators.

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

The Standards of Business Conduct Policy has been revised to reflect NHS England guidance published in 2024. Additional explanatory paragraphs have been included to support staff when assessing whether an individual declaration is required. In seeking to continue to increase compliance with this policy, an additional mechanism has been offered to medical and dental staff to record their interests. The importance of making appropriate declarations forms part of the welcome information for all new medical and dental staff and is included within the checklists for appraisal submissions. The Trust Secretary and The Local Counter Fraud Specialist are continuing to offer further training and support as required to enhance compliance.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This is considered in detail at the People and Organisational Development Committee, with annual reporting to the Board.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. In accordance with new requirements published in February 2025, the Trust's plan will be refreshed and approved by the Board to enable its publication by 31 July 2025 to meet the requirements of NHSE's published guidance.

Review of economy, efficiency and effectiveness of the use of resources
As a publicly funded organisation, the Trust operates with a statutory requirement to ensure that resources are used economically, efficiently and effectively. The Trust operates systems to ensure that this statutory requirement is met, and these were considered as part of the review of compliance with the Provider Licence:

- There is a robust business planning framework in place to ensure that all departments, divisions and the Trust as a whole has a clear view of available resources, the required resource for workforce and quality of service is confirmed, and prioritised decisions are taken regarding investments and service developments. A Financial Sustainability Group is in place and early planning was undertaken prior to publication of the 2025/26 priorities and operational planning guidance in January 2025. This is particularly important within the context of financial constraint in the NHS, the requirement to reduce spend and increase productivity across all organisations, NHS reorganisation and the merger of NHS England with the Department of Health and Social Care.

- The business planning process is overseen by the Executive Management Committee and assurance is provided to the Performance and Finance Committee. The business plan and financial framework is considered by the Board at various stages of its development. This included two seminars held during February and March 2025. The final plan was approved by the Board on 26 March 2025 including the budgets and cost improvement requirements set for divisions for the financial year ahead. Progress is monitored through the Accountability Framework, monthly updates to the committee and quarterly updates on progress in delivering the business plan.

- There are comprehensive Standing Financial Instructions in place, reviewed at least annually, which provide detailed controls to give assurance that resource is being used appropriately, covering:
    - financial transactions, including appropriate separation of decision-making, ordering and reception of goods and services
    - processes for authorising recruitment of staff and changing grading of posts, both within the set establishment and exceptionally to increase establishment within the financial year
    - processes for use of short-term staffing through internal bank or external agency arrangements
    - ensuring the procurement of goods and services is appropriate and delivers value for money.

- The Standing Financial Instructions include levels of authorisation/delegation to decisions reserved to the Board to ensure there is appropriate oversight and challenge. Significant investment decisions over £2.5 million, whether revenue or capital, require Board approval. All proposals for investment are supported by a business case that sets out the options and reasoning for the recommendations, at an appropriate level of detail for the size of the proposed investment.

- In September 2024 the Board approved a new Business Case Scrutiny and Oversight Group to act as an advisory group to consider business cases. This enables detailed discussion with non-executive directors and any subsequent revisions can be made to the business case prior to presentation to the Board.

Part of the medium-term work programme from the Internal Audit service is to review and assess the available level of assurance regarding the key controls for economy, efficiency and effectiveness and to advise the Audit and Risk Committee and the Board of areas where controls and systems can be improved.

In accordance with national requirements, the external auditor undertakes annually a review of the Trust's Value for Money arrangements which assesses the assurance available that the Trust has delivered against the three reporting criteria, financial sustainability, governance and improving economy, efficiency and effectiveness.

Information governance and data security
The responsibilities of the Trust in relation to data protection are taken very seriously to ensure that the way we use and look after sensitive personal information for both patients and staff is handled in accordance with statutory and legislative requirements.

The Trust recognises that it is trusted by patients and carers to handle sensitive data carefully and with full regard to the privacy rights of the individual. There are clear policies in place to ensure that data is handled appropriately, and that data is only accessed when there is a clear and appropriate need to do so. These are supported in practice by a range of processes, including regular reviews of departmental systems by the information governance team, monthly reporting, and by reviewing cases where access may have been inappropriate which, if shown, will be followed by appropriate disciplinary actions.

The Trust has appropriate data security arrangements, including password-restricted access to systems and information, and systems to record all access to records. All staff receive regular update training on information governance and security measures and the Trust takes appropriate disciplinary action against staff who have improperly accessed information.

The NHS Data Security and Protection Toolkit (DSPT) is an on-line self-assessment tool that enables organisations to measure their performance against the 10 data security standards set by the NHS National Data Guardian, submitted by 30 June each year. In July 2024 the committee received moderate assurance in relation to performance against the standards, and a medium confidence level following the independent assessment by our internal auditors. The Committee is assured that good progress is being made and will continue to monitor this. The current assessment is due to complete early in 2025/26.

The Audit and Risk Committee considers the assurance provided in relation to cyber security three times each year and monitors the management actions agreed following internal audit reports.

During the year ending 31 March 2025, seven incidents were reported to the Information Commissioner.

- Accessing the patient records of children, parents, and parents-to-be without lawful basis under the Children's Act 1989 and the Data Protection Act 2018
- Neighbour inappropriately accessed patient's records
- A patient's discharge notes are no longer available due to a scanning error
- NHS England mandated report relating to cyber security
- A small number of hard copy papers were shared at a Board meeting in error
- Access to a staff member's record by other staff members
- Alleged inappropriate access to a patient's record by a member of staff
- Staff disclosed details by telephone despite patient's notes confirming appropriate means of communication.

In each case, the Information Commissioner indicated that they were satisfied with the actions taken by the Trust and had no further requirements.

Data quality and governance
The Board recognises that accuracy of data is required to make appropriate decisions. There are control systems in place to mitigate the risk of inaccurate information being recorded, including systems of challenge and validation. As part of their medium-term plan of work, the internal audit service regularly reviews the systems of control and validation for performance information, and reports to the Audit and Risk Committee regarding the level of assurance available in relation to those systems. The reliability and quality of data is also reviewed by the internal audit provider as part of their assurance work.

The Performance and Finance Committee has responsibility for providing assurance regarding coding quality. Clinical coding is “the translation of medical terminology as written by the clinician to describe a patient’s complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format” which is then both nationally and internationally recognised. There are over 16,000 codes for different diagnoses and almost 10,000 for procedures or interventions. The Committee also receives detailed reports on bed modelling and seasonal variation plans and has fully considered the data supporting submission of the Trust’s plan in March 2025. The responsibility for oversight of clinical coding has transferred to the Audit and Risk Committee from 2025/26.

The Trust assures the quality and accuracy of its elective waiting time data through a regular validation process internally, with additional checks by the business informatics team to ensure the data reported is accurate. Significant work was undertaken in 2023/24 in response to the challenges experienced regarding the management of waiting lists in the previous year. The internal audit service confirmed substantial assurance was provided in 2024/25.

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 Board, the Audit and Risk Committee and the Quality and Patient Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Overall responsibility for the effectiveness of the systems of internal control lies with the Board, who retain responsibility for the approval of key items such as the Scheme of Delegation and the Schedule of Matters Reserved for Board decision. The Board regularly receives reports from its committees, which are subject to critical review, and draw the Board's attention to key matters which are being escalated for Board discussion or decision.

The main supporting committee for the Board's management of internal control systems is the Audit and Risk Committee. This Committee is composed entirely of non-executive directors and its membership includes recent and relevant financial experience. The Board has delegated authority to the Committee to review key internal control systems and make recommendations for improvement. It is regularly attended by the Chief Executive and Director of Finance, receives reports, agrees actions from the work of the internal audit and local counter fraud services and liaises on behalf of the Board with the external audit provider.

The Committee's regular agenda includes reviewing any cases where waivers to usual requirements have been required to ensure that these are appropriate, that an effective policy and process is in place for the management of conflicts of interest for staff, directors and others working with the Trust and that these have been declared appropriately and are in accordance with national policy, and progress in maintaining procedural documents. A report is received at every meeting relating to the delivery of management actions following internal audit reviews.

The Committee has robust processes in place and requires management to attend should a request be made to extend a target implementation date.

As part of the Committee's oversight, the mechanisms being used by other committees to review and revise BAF risks are reviewed at each meeting, whilst judgements and recommendations remain for those committees.

The Committee, by consent, receives assurance from the Quality and Patient Safety Committee in relation to the work of the clinical audit (outcomes) function. Sufficient assurance has been provided throughout 2024/25.

The internal audit service is provided by RSM LLP, on a contract basis. The service provides a range of internal audits, based on a medium-term strategy and an annual plan. This plan is considered by the Executive Management Committee prior to its approval by the Audit and Risk Committee. It is designed to ensure that all areas identified requiring review are included in a three-year cycle, whilst also having the flexibility to adjust to changing circumstances and ensuring some capacity to engage in additional reviews where a need is identified by the Board or management. The aim of the programme is to investigate areas where there may be concerns or improvement is required to seek to enhance the assurance provided. This annual plan has been shared with Board Committee Chairs and the procedure in place will be enhanced in 2024/25 to ensure it is shared prior to being confirmed.

The RSM Partner provided training to the Executive Management Committee in January 2025. The independent role of internal audit was described, the work with the Trust throughout the audit cycle and the importance of agreed actions addressing any weaknesses identified, using internal audit as an opportunity to improve.

During 2024/25, the following reviews were carried out, with the reported level of assurance available as indicated:

Review title	**Level of assurance**
Data Security Protection Toolkit	Moderate
In Employment Checks	Substantial
Medical Equipment Management	Partial
Cost Improvement Programme	Reasonable
Divisional Governance - Estates	Partial
Divisional Governance - Surgery	Partial
Waiting List Management	Substantial
EPR Governance	Reasonable
Temporary Staffing and Agency Usage	Reasonable
Medical Staff Rostering - Ipswich Emergency Department	Partial
Equality, Diversity and Inclusion	Substantial
Key Financial Controls	Substantial
Clinical Audit	Partial
Medical Bank Staffing/Bank doctors' recruitment	Partial

For those reviews where reasonable or substantial assurance is not provided, the Audit and Risk Committee requires the responsible Executive Director to attend to provide further assurance on the action to be taken and the timeframe for resolution:

- Medical Equipment Management - A trajectory of improvement had been demonstrated over the last three audits. Partial assurance related to one high priority action and processes being embedded across the Trust. There are in-date, effective, comprehensive policies, good control and design for record keeping and an effective overview of overdue and outstanding planned maintenance. However, divisions were not fully investigating and reporting on missing equipment. The Director of Estates and Facilities briefed on the improvements made over the last year and the implementation of a single EBME team. The Chair of the Quality and Patient Safety Committee provided assurance on discussion at that Committee, and

it was confirmed that missing equipment represented less than 1% of the total devices. The effectiveness of the Medical Devices Management Group was judged as satisfactory.

- Divisional Governance, Estates – The second audit providing partial assurance, whilst a trend of improvement was demonstrated. A clearly defined structure is in place surrounding budgetary control and the cost improvement programme. However, there were weaknesses identified in the tracking of delivery and the business planning process with objectives not having sufficient definition or confirmation of review. There had been delays in implementing planned mitigations for BAF7, recording of actions from divisional accountability meetings and the contract management process. A senior manager attended and provided additional information on contract management, redevelopment of the tracking template to ensure sufficient evidence was available and the development of an overarching performance dashboard. Concern was expressed about the leadership of this service, including reference to the extensive work relating to the future contract for soft facilities management, and the action being taken to mitigate that risk. Progress was required.

- Divisional Governance, Surgery – The governance framework was in place however there was non-compliance with controls including documenting business plan priorities, timescales and estimated costs, tracking productivity schemes at divisional level and meetings and action tracking required strengthening. The Associate Director of Operations provided additional context and advised that new controls had been implemented prior to the audit although these would take time to become embedded. The actions had either been implemented or could be put in place swiftly. As part of the divisional governance process over the next year those 17 measures would be reviewed every quarter. Ensuring Deputy attendance at meetings would be the most challenging. The Audit and Risk Committee confirmed completion of the actions at its meeting held in March 2025.

- Medical Staff Rostering, Ipswich Emergency Department – weaknesses identified within the rostering control framework and the actions required related to policies and procedures, lack of a standardised approval process and lack of evidence on value for money achieved and payments. The Director of Digital, Logistics and Operations provided additional context regarding use of Medirota in the Emergency Department, which is to be extended to the Medicine Division and confirmed his confidence that the necessary controls would be implemented.

- Clinical Audit - number of areas of weakness required attention including ensuring a review of the clinical audit leads to ensure they were being remunerated for the role, the sign off of clinical audit plans in a timely manner, and the levels of progress and completion of the national and local priority audits. There was a clear and robust governance structure in place although there was further work to do on documentation. The Interim Chief Medical Officer provided assurance on the plans in place to progress the actions, highlighting the importance of agreeing clinical audit plans in a timely manner and completion of the national and local priority audits. This issue was referred to the Quality and Patient Safety Committee to consider at its next meeting, seeking explicit assurance on progress. The internal auditors' support was welcomed in preparing the audit programme and appropriate reporting.

- Bank Doctors Recruitment – a number of weaknesses were identified that required attention. which included updating Standard Operating Procedures, evidencing all onboarding checks and revision of some job descriptions and Terms of Reference. Non-compliant individuals have been identified, and incidents have been logged through the Trust's incident management processes. The Director of People and Organisational Development attended and referred to the significant changes made to the onboarding process in advance of the national requirement to share information between organisations. There has been improvement and additional action was being taken where necessary. Members were reassured by the actions to embed the changes, to resolve the disconnect in reporting and wider communication, welcomed the plans being considered to review the benefits of a central rostering team and that action was being taken so promptly.

Throughout the year, the internal audit service had direct and immediate access to the Audit and Risk Committee through their Chair, and to the Accounting Officer. The Committee was advised of the importance of significant actions being completed within the agreed timeframes where a negative opinion had been confirmed.

The overall view of the internal audit on controls in place through the year is provided in the annual Head of Internal Audit opinion; for the 2024/25 year, that opinion reported that: *Overall the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective*.

Counter fraud arrangements are provided by RSM from the NHS Counter Fraud Authority by a named local counter fraud specialist. To ensure counter fraud resources are effective, there is a counter fraud plan and annual report which outlines the proactive, reactive and strategic counter fraud work undertaken for the Trust in 2024/25. The Audit and Risk Committee considers the fraud and bribery risk register as required, delegated to the local counter fraud specialist and the Deputy Director of Finance to revise on a quarterly basis. The Trust has an Anti-Fraud, Bribery and Corruption Policy and Procedure in place, and this was revised and approved in March 2025.

Conclusion
For the year ended 31 March 2025, and from then until the date of the signing of this statement, there are no significant internal control issues that have been identified.

Nick Hulme
Chief Executive and Accounting Officer
26 June 2025

Glossary/Abbreviations

A&E/ED/UEC	Accident and Emergency Department/Urgent and emergency care
ACE	Accrediting care at ESNEFT
AF	Accountability framework, our performance management process
AI	Artificial intelligence
AIS	Accessible Information Standard
AHPs	Allied health professionals
BAF	Board Assurance Framework
CETV	Cash equivalent transfer value (pensions)
CIP	Cost improvement programme
CQC	Care Quality Commission, who assess our quality of care
Capital	Spending on land and premises and provision, adaptation, renewal, replacement or demolition of buildings, equipment and vehicles
DHSC	Department of Health and Social Care
EDI	Equality, diversity and inclusion
EMC	Executive Management Committee
EPR	Electronic patient record
ESEOC	Essex and Suffolk Elective Orthopaedic Centre, Colchester
ESNEFT	East Suffolk and North Essex NHS Foundation Trust
FTE/WTE	Full/whole time equivalent (staffing)
GIRFT	The Getting it right first time programme
HR	Human resources
ICS/ICB/ICP	Integrated Care System/Board/Partnership
MECC	Making every contact count
MHPS	Maintaining high professional standards
MoU	Memorandum of understanding
NHSE	NHS England leads the NHS in England
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for health and Care Research
PALS	Patient advice and liaison service
PIFU	Patient initiated follow up
PLACE	Patient led assessment of the care environment
QI	Quality improvement
SNEE	Suffolk and North East Essex ICS
TFCD	Sustainability – task force on climate related disclosures
WRES/WDES	Equality – Workforce Race and Disability Equality Standards
WSFT	West Suffolk NHS Foundation Trust

Independent auditor's report to the Council of Governors

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST

Opinion
We have audited the financial statements of East Suffolk and North Essex NHS Foundation Trust for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income**,** the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and the related notes 1 to 27, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of East Suffolk and North Essex NHS Foundation Trust as at 31 March 2025 and of Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006.

Basis for opinion
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 Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on Foundation Trust's ability to continue as a going concern for a period to 30 September 2025**.**

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's ability to continue as a going concern.

Other information
The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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 course of 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Matters on which we are required to report by exception
The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer
As explained more fully in the 'Statement of Accounting Officer's responsibilities' set out on page 125 the Chief Executive is the accounting officer of East Suffolk and North Essex NHS Foundation Trust. The accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

As explained in the Governance Statement, the accounting officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

Auditor's responsibility for the 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

- We understood how East Suffolk and North Essex NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, head of internal audit, those charged with governance and director of governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes, through enquiry of employees to verify Foundation Trust policies, and through the inspection of employee handbooks and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance through understatement of non-NHS creditors manual accrual, inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

- To address our fraud risk around the manipulation of reported financial performance through understatement of non-NHS manual accrual, we tested the Foundation Trust's non-NHS manual accruals, challenging assumptions and corroborating the accruals to appropriate evidence. We performed a search of unrecorded liabilities using a lower testing threshold to detect expenditure incurred prior to year-end but not accrued.

- To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.

- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

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

Certificate

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of East Suffolk and North Essex NHS Foundation Trust.

E. Jackson
Ernst & Young LLP

Elizabeth Jackson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
26 June 2025

Annual Accounts for the year ended 31 March 2025

Annual accounts

Foreword to the accounts

East Suffolk and North Essex NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by East Suffolk and North Essex NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Nick Hulme

Chief Executive

26 June 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	1,154,895	1,010,740
Other operating income	4	64,795	59,555
Operating expenses	7	(1,243,952)	(1,069,836)
Operating surplus/(deficit)		**(24,262)**	**459**
Finance income		3,040	4,260
Finance expenses		(3,833)	(6,174)
PDC dividends payable		(13,590)	(10,450)
Net finance costs		**(14,383)**	**(12,364)**
Deficit for the year		**(38,645)**	**(11,905)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Other reserves movements		2	-
Impairments charged to the revaluation reserve	12	(10,312)	(13,082)
Revaluations	12,15	9,527	35,468
Total comprehensive income/(expense) for the year		**(39,428)**	**10,481**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	11	37,322	34,319
Property, plant and equipment	12	525,946	498,783
Right-of-use assets	15	31,364	63,557
Receivables	17	2,260	2,133
Total non-current assets		**596,892**	**598,792**
Current assets			
Inventories		17,339	14,817
Receivables	17	37,548	33,534
Cash and cash equivalents	18	62,176	79,254
Total current assets		**117,063**	**127,605**
Current liabilities			
Trade and other payables	19	(118,686)	(129,558)
Borrowings	20	(10,884)	(12,376)
Provisions	21	(1,749)	(3,511)
Other liabilities		(2,588)	(2,321)
Total current liabilities		**(133,907)**	**(147,766)**
Total assets less current liabilities		**580,048**	**578,632**
Non-current liabilities			
Borrowings	20	(87,886)	(93,408)
Provisions	21	(2,324)	(2,650)
Other liabilities		-	(326)
Total non-current liabilities		**(90,210)**	**(96,384)**
Total assets employed		**489,838**	**482,247**
Financed by			
Public dividend capital		565,021	518,002
Revaluation reserve		96,452	99,768
Other reserves		754	754
Income and expenditure reserve		(172,389)	(136,277)
Total taxpayers' equity		**489,838**	**482,247**

The notes on pages 160 to 188 form part of these accounts.

Nick Hulme

Chief Executive

26 June 2025

Statement of Changes in Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024	**518,002**	**99,768**	**754**	**(136,277)**	**482,247**
Total comprehensive income for the year					
Deficit for the year	-	-	-	(38,645)	**(38,645)**
Net impairments	-	(10,312)	-	-	**(10,312)**
Revaluations	-	9,527	-	-	**9,527**
Total comprehensive income/(expense) for the year	-	(785)	-	(38,645)	**(39,430)**
Transfer to retained earnings on disposal of assets	-	(859)	-	859	**-**
Public dividend capital received	47,019	-	-	-	**47,019**
Other reserves movements	-	(1,672)	-	1,674	**2**
Total reserve movements for the year	47,019	(3,316)	-	(36,112)	**7,591**
Taxpayers' equity at 31 March 2025	**565,021**	**96,452**	**754**	**(172,389)**	**489,838**

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2023	**440,866**	**79,029**	**754**	**(114,147)**	**406,502**
Application of IFRS16 measurement principles to PFI liability on 1 April 2023				(11,872)	**(11,872)**
Total comprehensive income for the year					
Deficit for the year	-	-	-	(11,905)	**(11,905)**
Net impairments	-	(13,082)	-	-	**(13,082)**
Revaluations	-	35,468	-	-	**35,468**
Total comprehensive income for the year	-	22,386	-	(11,905)	**10,481**
Transfer to retained earnings on disposal of assets	-	(1,647)	-	1,647	**-**
Public dividend capital received	77,136	-	-	-	**77,136**
Total reserve movements for the year	77,136	20,739	-	(10,258)	**87,617**
Taxpayers' equity at 31 March 2024	**518,002**	**99,768**	**754**	**(136,277)**	**482,247**

Information on Reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves represents the balance of working capital inventories, and plant and equipment assets transferred to the Trust as part of the disaggregation and dissolution of Essex and Herts Community NHS Trust in 2001. The reserve is held in perpetuity.

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

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(24,262)	459
Non-cash income and expense:			
Depreciation and amortisation	7	37,265	35,222
Net impairments	8	43,797	11,146
Income recognised in respect of capital donations	4	(1,538)	(402)
Losses from disposal of property, plant and equipment		168	761
Amortisation of PFI deferred credit		(326)	(326)
(Increase)/decrease in receivables and other assets		(2,621)	11,188
Increase in inventories		(2,522)	(1,247)
Increase/(decrease) in payables and other liabilities		10,053	(27,103)
Decrease in provisions		(2,109)	(1,978)
Net cash flows from operating activities		**57,905**	**27,720**
Cash flows from investing activities			
Interest received		3,075	4,214
Purchase of intangible assets		(28,773)	(1,700)
Purchase of property, plant and equipment		(67,009)	(78,277)
Sales of property, plant and equipment		26	2,025
Receipt of cash donations to purchase assets		1,055	-
Net cash flows used in investing activities		**(91,626)**	**(73,738)**
Cash flows from financing activities			
Public dividend capital received		47,019	77,136
Loans repaid to the Department of Health and Social Care		(1,188)	(1,188)
Other loans repaid		(114)	(140)
Capital element of lease liability repayments		(10,797)	(10,013)
Capital element of PFI and other service concession payments		(1,888)	(2,250)
Interest on loans		(227)	(253)
Other interest		(7)	(22)
Interest element of lease liability repayments		(983)	(974)
Interest paid on PFI and other service concession obligations		(1,195)	(1,038)
PDC dividend paid		(13,977)	(11,123)
Net cash flows from financing activities		**16,643**	**50,135**
Increase/(Decrease) in cash and cash equivalents		**(17,078)**	**4,117**
Cash and cash equivalents at 1 April		**79,254**	**75,137**
Cash and cash equivalents at 31 March	18	**62,176**	**79,254**

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

NHS England 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 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories, right-of-use assets and liabilities and certain financial assets and financial liabilities.

Note 1.2 Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

This year the Trust reported a deficit of £38.6m, although £43.8m of this deficit was driven by impairments which have no cash impact. However, for 2024/25 the Trust exceeded its annual financial control total of £0.25m, which was set by NHSE at the start of the year, as when measuring financial performance against this control total certain items are excluded, e.g. capital donations and impairments. After adjusting for these items, the Trust met its control total and delivered an increased surplus of £3.5m.

The Trust has maintained a strong cash balance throughout 2024/25, and at 31 March 2025, after accounting for the in-year payment of a higher than expected capital payables balance brought forward in relation to the 2023/24 capital expenditure programme, the Trust closed out the year with a cash balance of £62.2m (compared to £79.3m at 31 March 2024).

The Trust has developed a plan for 2025/26 which was submitted to NHS England on 30 April 2025. This plan was constructed in line with current national NHS planning guidance and forecasts the delivery of a break-even position for the year. Within this plan the Trust has planned income of £1.2b, the substantial portion of which is backed by NHS contracts. The plan includes fully funded provision for all borrowing repayments and payment of all liabilities due in the year, delivering a forecast cash balance of £47.8m as at 31 March 2026. The Trust's plan includes £43.9m of cost improvements which represents 3.6% of operating expenditure and is below the overall suggested efficiency improvements recommended in the planning guidance in order to deliver national priorities within funding allocations.

The Trust's plan has been fully incorporated into the Suffolk and North East Essex Integrated Care Board's Integrated Care System financial plans, which includes the continued provision of services by the Trust. In formulating the plan, the Directors of the Trust have considered, and concluded, that there are no local or national policy decisions that are likely to affect the continued funding and provision of NHS services by the Trust. Additionally, for 2025/26 the ICB, as well as the Trust, were awarded the lowest risk rating in terms of not necessitating NHSE planning intervention.

Our going concern assessment is made up to 30 September 2026; this includes the first half of the 2026/27 financial year. NHS operating and financial guidance is not yet issued for that year, and so the Trust has assumed that the current contracting arrangements with Integrated Care Boards continue in 2026/27 to ensure that the Trust's operations are at least commensurate with activity and performance planned for delivery in 2025/26. Inflationary cost factors after March 2026 on pay and non-pay costs are anticipated to be matched by inflationary increases to funding in the 2026/27 financial year.

The Trust has prepared a prudent cash forecast modelled on the above expectations of funding during the going concern period to 30 September 2026. As at that date the forecast cash balance of £35.7m shows sufficient liquidity for the Trust to continue to operate during the period without the need for support. Interim support can be accessed if it were required, but there is currently no such identified requirement, and a sufficient cash buffer is maintained across the period.

Financial governance arrangements in place within the Trust support the appropriate planning, forecasting and management of finances, as established through the Standing Orders, the Standing Financial Instructions and Scheme of Delegation, all of which have been reviewed and approved by the Trust board in April 2025. These, along with the financial and operating policies of the Trust such as the Treasury Management Policy, provide the framework for financial decision-making and support the preparedness and flexibility for overcoming financial challenges.

In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the financial statements.

Note 1.3 Interests in Other Entities

The Trust has not consolidated the activities of the East Suffolk and North Essex NHS Foundation Trust Charitable Fund, whose activities are not considered to be material.

Note 1.4 Revenue from Contracts with Customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office for National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year-end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity, with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

The Trust also receives funding from NHS England for training and education, which is accounted for under IFRS15, and recognised when the training/activity takes place.

Note 1.5 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on Other Goods and Services

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

Note 1.7 Property, Plant and Equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent Expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.7.2 Measurement

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

Land and building assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of land and buildings 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. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

Depreciation commences after the recognition of the asset and ceases upon the disposal of the asset. Assets in the course of construction are not depreciated until the asset is brought into use.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

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

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

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

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

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

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and Grant Funded Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and life cycle replacement of components of the asset.

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Assets are subsequently accounted for as property, plant and equipment.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

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

Initial Application of IFRS 16 Liability Measurement Principles to PFI Liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Note 1.7.6 Useful Lives of Property, Plant and Equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	2	84
Plant & machinery	5	15
Transport equipment	3	7
Information technology	3	7

Leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible Assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software
Software which is integral to the operation of hardware, e.g. 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, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.
Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation 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.

For all categories of intangible assets, the Trust considers that amortised historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the amortisation methods used reflect the consumption of the asset.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful Lives of Intangible Assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. Useful lives are estimated to be the period over which the Trust expects to obtain economic benefits or service potential from the asset and are derived from past experience of similar assets or from knowledge gained from service users. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software Licences	5	5

Note 1.9 Inventories

Inventories are valued at current cost, with the exception of drug stocks on the Colchester site which are valued at average cost (a different costing methodology due to system functionality over which the Trust has no control and for which any difference in inventory valuation would be immaterial). Current cost is considered to be a reasonable approximation to the lower of cost and net realisable value due to the high turnover of stocks.

Obsolete and defective stocks are charged to the Statement of Comprehensive Income as an expense when identified as such.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.10 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial Assets and Financial Liabilities

Note 1.11.1 Recognition

Financial assets and 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, i.e. when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and Measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial Assets and Financial Liabilities at Amortised Cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of Financial Assets
For all financial assets measured at amortised cost, including lease receivables and contract receivables, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract, other receivables, and lease receivables, measuring expected losses at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meets the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.12.1 Leases for Right of Use Assets

Recognition and Initial Measurement
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent Measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly different to market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset (see note 1.18).

In accordance with this guidance, the Trust previously considered that the cost model was a suitable proxy for the value of right of use assets, and therefore did not employ a revaluation model for subsequent measurement of right of use assets. However, in 2024/25, a professional valuation has been undertaken of these assets which are now held at a revalued carrying amount as at 31 March 2025.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as Lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Note 1.12.2 Operating Leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at:
https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 1.14 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 1.15 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 1.16 Standards, Amendments and Interpretations in Issue but not yet Effective or Adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £423.0m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £393.7m as at 31 March 2025.

Note 1.17 Critical Judgements in Applying Accounting Policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or, in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Property, Plant and Equipment Valuation

Critical judgements have been applied in accounting for specialised buildings specifically in relation to the valuation assumptions. Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore, the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

In determining the MEA, the Trust has to make assumptions that are practically achievable, however, the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the

services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because the chosen locations and the catchment areas for patients using the Trust's services has been taken into account when deciding on appropriate alternative sites.

The Trust does not intend to implement any of the changes to its property, plant and equipment that are implied by the theoretical assumptions that underpin the MEA valuation.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for both Colchester Hospital and Ipswich Hospital would be a multi-storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, under-utilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

The MEA valuations used by the Trust have been provided to the Trust by Newmark (formerly called Gerald Eve LLP). The Trust has used component lives based upon information provided by Newmark to depreciate buildings on a component basis.

Adoption of IFRS 16 Leases
Under IFRS 16, when initially measuring right-of-use assets and lease liabilities, the Trust needs to determine the lease term. IFRS 16 defines the lease term as the non-cancellable period for which the Trust has the right to use an underlying asset, together with both i) periods covered by an option to extend the lease if the lessee is reasonably certain to exercise that option; and ii) periods covered by an option to terminate the lease if the lessee is reasonably certain not to exercise that option.

The Trust has several instances of leased properties with NHS Property Services for which there are no formally documented leasing agreements, and therefore the Trust has applied accounting judgements to these leases, most notably making an assumption regarding the term of the lease.

Where no formal lease is in place, the Trust has determined that it is appropriate to align the lease term to that of the community-based service contract, whose services are largely provided from these leased properties, the underlying assumption being that the leased property is necessary only to provide those services, and should the contract be awarded to an alternative provider in the future, the leasing arrangements would also be transferred at the same time.

Valuation of Right of Use Property Assets
A full valuation assessment of the Trust's right of use leased properties has been undertaken by Newmark as at 31 March 2025. In determining their valuation the valuer has undertaken full site visits, reviewed all available lease documentation, made an assessment of gross internal areas and taken into account remaining lives of the lease arrangements. The valuer has performed the valuation using their professional judgement upon which the Trust has placed reliance.

Application of IFRS 16 on PFI Schemes
In applying IFRS 16 to the Trust's PFI contract, the resultant PFI lease liability is assessed on the future minimum lease payments, which in turn are based on the current annual contract price, for the remainder of the contract. The Trust's contract is subject to an annual price change based upon the Retail Prices Index (RPI) each December. No estimate is made for future inflationary or deflationary changes to the annual contract price resulting from changes to the RPI, which would increase or decrease the liability from the current carrying value accordingly.

Non-Consolidation of Charitable Funds
International Accounting Standard number 27 (IFRS10) requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS10 defines a subsidiary as an entity that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities. The Trust is Corporate Trustee of the Charitable Fund and meets the definition of control.

Materiality is an overriding consideration in preparation of the accounts. The international Accounting Standards Board (IASB) states that "Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements".

The net assets of the Charitable Fund are less than 2% of the Trust's net assets. Charitable income is less than 0.5% of Trust income. The Directors therefore consider that the significant amount of work which would be necessary to consolidate the accounts of the Charitable Fund with those of the Trust is not justified on the grounds of materiality.

Note 1.18 Sources of Estimation Uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property, Plant and Equipment Valuation
The Trust considers that the valuation of property, plant and equipment assets poses a significant risk relating to estimates and assumptions about their carrying value. To mitigate the risk of material misstatement, the Trust engages the professional services and advice of a professional RICS qualified valuer as detailed in note 14. The qualified valuer is recognised as a suitable provider of a range of valuation and surveying services to public sector bodies and their estimates can be relied upon in respect of these services, including estimates of the remaining useful economic lives of property assets.

The key assumptions that are most likely to affect the valuations are:

Cost data: The Valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the valuer relies on indices that are informed through the Building Cost Information Service (BCIS) all in tender price index, which provides statistical data across a wide range of buildings and more accurately reflects tender levels in the industry. The BCIS and location factor for the alternative site are applied to the costs associated with the construction of the Modern Equivalent Asset and allows the costs to be adjusted to the valuation date. The Trust requires asset valuations at a given valuation date for accounting purposes, and the valuer assists in providing these asset valuations having regard to the forecast tender cost information available at the time. However, the final BCIS figure does not become fixed until some 6 to 9 months after the relevant calendar valuation date which could give rise to some variation to the values reported at the valuation date.

Gross Internal Area (GIA): The GIA of the Trust's buildings is a component of the overall asset value as the BCIS and location factor for the alternative site are applied to GIA figures in estimating the costs associated with the construction of the Modern Equivalent Asset. In performing their valuation, the Trust's valuer makes a conservative allowance for a reduction in land requirements, void and under-utilised space and takes into consideration the need to adjust historical building layouts compared to modern building design and legislative requirements. Therefore, changes to these variables could lead to differences in the values reported at the valuation date.

The valuer also reviewed the useful economic lives of the Trust buildings. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives by category of an asset are detailed in note 1.7.6.

Valuation of Right of Use Property Assets

Following transition to IFRS 16 accounting for right of use assets, the Trust has applied the cost model as a proxy for valuation on the basis that this is a suitable method of valuation for such assets, especially where these are leases between public sector bodies and there is no suitable alternative market for the lease of these properties.

Subsequently, in October 2024, Community Health Partnerships (CHP), from whom the Trust leases a range of properties, commissioned "a review of the Local Improvement Finance Trust (LIFT) programme sub-leasing model to understand the relative costs and benefits against the wider NHS portfolio and commercial alternatives".[1]

Whist the review highlights a range of benefits of the LIFT programme, it also reaffirms that these leases are usually of a fixed term (average lease term across the NHS is 27 years) and lease payments are fixed at lease agreement with annual RPI price inflation increases. However, whilst this pricing model provides a degree of cost certainty for the NHS, in terms of right of use valuations, the review highlights a potential difference between LIFT payments (£424 per sqm) and alternative commercial rental payments (£200 - £300 per sqm), although these would also be subject to additional costs such as planned maintenance, management, repairs and insurance.

On the basis that this review was enough to demonstrate a range of variability between the CHP rental pricing arrangements and those that might be obtained from a commercial lease, the Trust decided to undertake a valuation exercise of leased properties as at 31 March 2025, and engaged Newmark as its valuer to perform this assessment. In applying their professional judgement to the Trust's portfolio of leased properties, Newmark have lowered the valuation amounts for two CHP properties (Fryatt Hospital and Colchester Primary Care Centre), along with the lease for the Trust's nuclear medicine facility which is also deemed to be outside a range of a commercial lease if using lease cost as a proxy for valuation.

The net impact of these lease revaluations is an impairment of £28.1m which has been accounted for in 2024/25. The Trust considers this to be a change in estimation technique (as prompted through the findings of the CHP review) under the requirements of IAS 8 and is therefore reported as a prospective accounting change under this Standard.

1. NHS Local Improvement Finance Trust (LIFT) Occupancy Cost Assessment (PwC, October 2024)

Provisions

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. Provisions are based on estimates using as much relevant and reliable information as is available at the time the accounts are prepared. These provisions are estimates of the likely actual costs of future cash flows which are dependent upon future events. Any subsequent difference between the expected and actual amounts will be accounted for in the period when such a determination is made. The carrying amount of the Trust's provisions are detailed in note 21 to the accounts.

Adoption of IFRS16 Leases

In applying a judgement over the determination of the lease term for properties leased from NHS Property Services, where no formal lease documentation exists, the Trust has used the remaining duration of the community-based service contracts, namely 5.5 years for the Suffolk community contract and 10 years for the North Essex community contract.

As the lease term is a key characteristic in determining the initial value of the right-of-use asset and corresponding liability, the Trust recognises there is a degree of estimation uncertainty in the application of these notional lease terms. However, for this collection of leases, utilising a different lease term would increase/decrease the carrying value of both the right-of-use asset and liability by an equal amount with a nil overall impact on the Trust's total assets employed. Furthermore, any impact on lease interest charges would be immaterial and would be offset by altered depreciation charges. In addition, there would have been no bearing on cash as the lease payments do not alter as a result of a change to this accounting judgement.

Note 2 Operating Segments

The Trust has determined that the chief operating decision maker (as defined by IFRS 8 Operating Segments) is the Board of Directors, on the basis that all strategic decisions are made by the Board.

All of the Trust's activities are in the provision of healthcare, which whilst provided across two main hospital sites, is an aggregate of all the individual specialty components included therein. Similarly, the large majority of the Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature.

Consequently, the Board of Directors considers that all the Trust's activities fall under a single segment of provision of healthcare, and no further segmental analysis is therefore required.

Note 3 Operating Income from Patient Care Activities

Note 3.1 Income from Patient Care Activities (by Nature)

	2024/25 £000	2023/24 £000
Acute services		
Aligned payment and incentive income [1]	927,090	812,197
High-cost drugs income from commissioners (excluding pass-through costs)	55,993	52,921
Other NHS clinical income	2,373	2,044
Community services		
Aligned payment and incentive income	117,703	110,546
All services		
Private patient income	2,059	1,911
Agenda for change pay offer central funding [2]	1,922	399
Additional pension contribution central funding [3]	39,368	23,741
Other clinical income	8,387	6,981
Total income from activities	**1,154,895**	**1,010,740**

1. Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 National Tariff payments system documents. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

2. Additional funding was made available directly to Providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

3. Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

Note 3.2 Income from Patient Care Activities (by Source)

	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	115,572	147,116
Integrated care boards	1,026,504	852,571
Other NHS providers	2,279	2,044
NHS other	94	113
Local authorities	1,617	2,416
Non-NHS: private patients	2,059	1,911
Non-NHS: overseas patients (chargeable to patient)	781	244
Injury cost recovery scheme	1,788	1,553
Non-NHS: other	4,201	2,772
Total income from activities	**1,154,895**	**1,010,740**

Note 3.3 Income from Overseas Visitors

	2024/25 £000	2023/24 £000
Income recognised this year	781	244
Cash payments received in-year	142	128
Amounts added to provision for impairment of receivables	643	167
Amounts written off in-year	16	45

Note 4 Other Operating Income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Other operating income from contracts with customers						
Research and development	4,289	-	**4,289**	3,090	-	**3,090**
Education and training	30,980	-	**30,980**	27,553	-	**27,553**
Non-patient care services to other bodies	2,100	-	**2,100**	2,724	-	**2,724**
Income in respect of employee benefits accounted on a gross basis	2,256	-	**2,256**	3,334	-	**3,334**
Car parking income	3,967	-	**3,967**	3,449	-	**3,449**
Pharmacy sales	902	-	**902**	1,073	-	**1,073**
Staff contribution to employee benefit schemes	2,717	-	**2,717**	2,019	-	**2,019**
Restaurant sales	1,074	-	**1,074**	1,158	-	**1,158**
Facilities Management services	1,227	-	**1,227**	1,243	-	**1,243**
Crèche services	1,055	-	**1,055**	727	-	**727**
Other non-contract operating income						
Gains on disposal of property, plant and equipment	-	242	**242**	-	76	**76**
Education and training - notional income from apprenticeship fund	-	1,436	**1,436**	-	1,150	**1,150**
Receipt of capital grants and donations						
Donations of physical assets from NHS charities	-	483	**483**	-	402	**402**
Received from NHS charities	-	1,055	**1,055**	-	1,156	**1,156**
Equipment and consumables donated from DHSC for COVID-19 response	-	-	**-**	-	185	**185**
Rental revenue from operating leases	-	925	**925**	-	896	**896**
Amortisation of PFI deferred credits	-	326	**326**	-	326	**326**
Other income	9,761	-	**9,761**	8,994	-	**8,994**
Total other operating income relating to continuing operations	**60,328**	**4,467**	**64,795**	**55,364**	**4,191**	**59,555**

Note 5 Income from Activities Arising from Commissioner Requested Services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	1,103,159	977,708
Income from services not designated as commissioner requested services	51,736	33,032
Total	**1,154,895**	**1,010,740**

Note 6 Operating Leases

The Trust as Lessor

This note discloses income generated in operating lease agreements where East Suffolk and North Essex NHS Foundation Trust is the lessor.

The Trust's operating lease income is from the annual rents charged by the Trust for the use of its premises. Lease income from operating leases is recognised in income on a straight-line basis over the lease term, irrespective of when the payments are due.

Note 6.1 Operating Lease Income

	2024/25 £000	2023/24 £000
Operating lease revenue		
Minimum lease receipts	925	896
Total in-year operating lease income	**925**	**896**

Note 6.2 Future Lease Receipts

	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due:		
not later than one year	921	892
later than one year and not later than two years	850	820
later than two years and not later than three years	841	801
later than three years and not later than four years	841	793
later than four years and not later than five years	841	793
later than five years	6,558	13,046
Total	**10,852**	**17,145**

Note 7 Operating Expenses

	2024/25 £000	2023/24 £000
Purchase of healthcare from NHS and DHSC bodies	10,261	10,334
Purchase of healthcare from non-NHS and non-DHSC bodies	53,265	39,712
Staff and executive director's costs	739,326	655,624
Remuneration of non-executive directors	196	177
Supplies and services - clinical (excluding drugs costs)	104,489	97,632
Supplies and services – general	28,145	24,617
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	103,828	92,843
Inventories written down	516	166
Consultancy costs	259	76
Establishment	10,270	7,649
Premises - business rates collected by local authorities	3,472	3,350
Premises – other	59,203	46,430
Transport (business travel only)	2,557	2,140
Transport - other (including patient travel)	3,761	2,915
Depreciation on property, plant and equipment	34,691	32,990
Amortisation on intangible assets	2,574	2,232
Net impairments	43,797	11,146
Loss on disposal of property, plant and equipment	3	837
Loss on disposal of intangibles	407	-
Movement in credit loss allowance: contract receivables	545	(744)
Decrease in other provisions	238	(38)
Change in provisions discount rate	2	(31)
Fees payable to the external auditor - statutory audit [1]	469	418
Internal audit costs	138	111
Clinical negligence	28,174	27,827
Legal fees	218	(53)
Insurance	1,372	1,066
Education and training	3,809	4,116
Expenditure on short term leases (less than 12 months)	(8)	72
Charges to operating expenditure for on-SoFP PFI schemes	1,188	874
Recruitment fees	165	4
Grants	130	85
Professional services	2,861	3,008
Licence fees	93	175
Car parking & security	483	533
Hospitality	45	52
Losses, ex gratia & special payments	50	46
Other services, e.g. external payroll	897	593
Other	2,063	852
Total operating expenditure	**1,243,952**	**1,069,836**

1. Limitation on auditor's liability
The limitation on auditor's liability for external audit work is £2 million (2023/24: £2 million). Audit fees are disclosed inclusive of VAT. Other remuneration paid to the external auditor was nil (2023/24: nil).

Note 8 Impairment of Assets

	2024/25 £000	2023/24 £000
Net impairments charged to operating surplus resulting from:		
Changes in market price	43,797	11,146
Total net impairments	**43,797**	**11,146**

The impairments recognised in 2023/24 and 2024/25 are the result of the revaluation of the Trust's building assets.

Note 9 Employee Benefits

	2024/25 £000	2023/24 £000
Salaries and wages	522,220	465,637
Social security costs	54,318	49,701
Apprenticeship levy	2,641	2,439
Employer's contributions to NHS pensions	99,939	78,101
Pension cost – other	104	127
Early termination benefits	378	270
Temporary staff (including agency)	60,147	60,086
Total staff costs	**739,747**	**656,361**
Of which:		
Costs capitalised as part of assets	421	737

Note 9.1 Retirements Due to Ill Health

During 2024/25 there were 5 early retirements from the Trust agreed on the grounds of ill health (5 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £612k (£442k in 2023/24).

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

Note 10 Pension Costs

The Trust offers two pension schemes to staff, the NHS pension scheme and the National Employment Savings Trust (NEST).

NHS Pension Scheme

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

NEST

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Pension Scheme, the Trust used an alternative pension scheme called NEST to fulfil its Automatic Enrolment obligations. NEST is a defined

contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which for the tax year 2024/25 were £6,240 up to £50,270. Total contributions are 8%, with employee contributions at 4%, employer contributions at 3% and government contributions (tax relief) at 1%. More details on NEST can be found on the NEST website www.nestpensions.org.uk.

Note 11 Intangible Assets

Note 11.1 Intangible Assets – 2024/25

	Software licences	Assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2024	**26,787**	**26,043**	**52,830**
Additions	494	5,583	**6,077**
Reclassifications	22	(22)	**-**
Disposals/derecognition	(1,864)	-	**(1,864)**
Valuation/gross cost at 31 March 2025	**25,439**	**31,604**	**57,043**
Amortisation at 1 April 2024	**18,511**	-	**18,511**
Provided during the year	2,574	-	**2,574**
Reclassifications	93	-	**93**
Disposals/derecognition	(1,457)	-	**(1,457)**
Amortisation at 31 March 2025	**19,721**	**-**	**19,721**
Net book value at 31 March 2025	**5,718**	**31,604**	**37,322**
Net book value at 1 April 2024	**8,276**	**26,043**	**34,319**

Note 11.2 Intangible Assets – 2023/24

	Software licences	Assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2023	**27,660**	**17**	**27,677**
Additions	680	26,026	**26,706**
Disposals/derecognition	(1,553)	-	**(1,553)**
Valuation/gross cost at 31 March 2024	**26,787**	**26,043**	**52,830**
Amortisation at 1 April 2023	**17,832**	**-**	**17,832**
Provided during the year	2,232	-	**2,232**
Disposals/derecognition	(1,553)	-	**(1,553)**
Amortisation at 31 March 2024	**18,511**	**-**	**18,511**
Net book value at 31 March 2024	**8,276**	**26,043**	**34,319**
Net book value at 1 April 2023	**9,828**	**17**	**9,845**

Note 12 Property, Plant and Equipment

Note 12.1 Property, Plant and Equipment – 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024	**19,800**	**290,320**	**122,281**	**121,474**	**18**	**17,507**	**571,400**
Additions	-	802	58,730	8,773	-	57	**68,362**
Impairments charged to operating expenses	-	(19,073)	-	-	-	-	**(19,073)**
Reversal of impairments	-	994	-	-	-	-	**994**
Revaluations	2,250	2,667	-	-	-	-	**4,917**
Impairments charged to revaluation reserve	-	(13,143)	-	-	-	-	**(13,143)**
Reclassifications	-	109,260	(126,109)	14,792	-	2,057	**-**
Disposals/derecognition	-	-	-	(7,166)	-	(53)	**(7,219)**
Reclassifications from ROU assets	-	-	-	3,058	-	-	**3,058**
Valuation/gross cost at 31 March 2025	**22,050**	**371,827**	**54,902**	**140,931**	**18**	**19,568**	**609,296**
Accumulated depreciation at 1 April 2024	**-**	**-**	**-**	**62,290**	**5**	**10,322**	**72,617**
Provided during the year	-	10,185	-	12,824	3	2,493	**25,505**
Impairments charged to operating expenses	-	(1,465)	-	-	-	-	**(1,465)**
Reversal of impairments	-	(1,381)	-	-	-	-	**(1,381)**
Revaluations	-	(4,508)	-	-	-	-	**(4,508)**
Impairments charged to revaluation reserve	-	(2,831)	-	-	-	-	**(2,831)**
Reclassifications	-	-	-	(93)	-	-	**(93)**
Disposals/derecognition	-	**-**	-	(7,165)	-	(53)	**(7,218)**
Reclassifications from ROU assets	-	-	-	2,724	-	-	**2,724**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**70,580**	**8**	**12,762**	**83,350**
Net book value at 31 March 2025	**22,050**	**371,827**	**54,902**	**70,351**	**10**	**6,806**	**525,946**
Net book value at 1 April 2024	**19,800**	**290,320**	**122,281**	**59,184**	**13**	**7,185**	**498,783**

Note 12.2 Property, Plant and Equipment – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & Machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023	**20,960**	**262,756**	**86,550**	**108,443**	**18**	**15,800**	**494,527**
Additions	-	1,448	77,992	2,907	-	31	**82,378**
Impairments charged to operating expenses	(11)	(21,990)	-	-	-	-	**(22,001)**
Reversal of impairments	-	8,320	-	-	-	-	**8,320**
Revaluations	136	26,604	-	-	-	-	**26,740**
Impairments charged to revaluation reserve	(1,285)	(11,797)	-	-	-	-	**(13,082)**
Reclassifications	-	25,689	(42,189)	13,775	-	2,725	**-**
Disposals/derecognition	-	(710)	(72)	(3,651)	-	(1,049)	**(5,482)**
Valuation/gross cost at 31 March 2024	**19,800**	**290,320**	**122,281**	**121,474**	**18**	**17,507**	**571,400**
Accumulated depreciation at 1 April 2023	**-**	**-**	**-**	**54,265**	**3**	**9,104**	**63,372**
Provided during the year	-	9,954	-	11,520	2	2,267	**23,743**
Impairments charged to operating expenses	-	(2,553)	-	-	-	-	**(2,553)**
Revaluations	-	(7,383)	-	-	-	-	**(7,383)**
Disposals/derecognition	-	(18)	-	(3,495)	-	(1,049)	**(4,562)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**62,290**	**5**	**10,322**	**72,617**
Net book value at 31 March 2024	**19,800**	**290,320**	**122,281**	**59,184**	**13**	**7,185**	**498,783**
Net book value at 1 April 2023	**20,960**	**262,756**	**86,550**	**54,178**	**15**	**6,696**	**431,155**

Note 12.3 Property, Plant and Equipment Financing – 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & equipment	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Owned – purchased	22,050	337,165	54,902	68,952	10	6,806	**489,885**
On-SoFP PFI contracts and other service concession arrangements	-	33,691	-	-	-	-	**33,691**
Owned – donated/granted	-	971	-	1,399	-	-	**2,370**
NBV total at 31 March 2025	**22,050**	**371,827**	**54,902**	**70,351**	**10**	**6,806**	**525,946**

Note 12.4 Property, Plant and Equipment Financing – 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & equipment	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Owned – purchased	19,800	255,400	122,281	58,005	13	7,185	**462,684**
On-SoFP PFI contracts and other service concession arrangements	-	33,968	-	-	-	-	**33,968**
Owned – donated/granted	-	952	-	1,179	-	-	**2,131**
NBV total at 31 March 2024	**19,800**	**290,320**	**122,281**	**59,184**	**13**	**7,185**	**498,783**

Note 12.5 – Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	461	911	-	-	-	-	**1,372**
Not subject to an operating lease	21,589	370,916	54,902	70,351	10	6,806	**524,574**
Total net book value at 31 March 2025	**22,050**	**371,827**	**54,902**	**70,351**	**10**	**6,806**	**525,946**

Note 12.6 – Property, Plant and Equipment Assets Subject to an Operating Lease (Trust as a Lessor) – 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	365	1,661	-	-	-	-	**2,026**
Not subject to an operating lease	19,435	288,659	122,281	59,184	13	7,185	**496,757**
Total net book value at 31 March 2024	**19,800**	**290,320**	**122,281**	**59,184**	**13**	**7,185**	**498,783**

Note 13 Donations of Property, Plant and Equipment

The Trust received donated equipment from the East Suffolk and North Essex NHS Foundation Trust Charitable Fund valued at £483k (2023/24: £402k). In 2024/25 the Trust received no personal protective equipment (2023/24: £185k) centrally procured by DHSC to support COVID.

Note 14 Revaluations of Property, Plant and Equipment

In accordance with IAS 16, all property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at current value. All land and buildings are restated to current value using professional valuations at least every five years, with an interim valuation at 3 years. All plant and equipment, transport equipment and information technology is valued using a depreciated historical costs basis as a proxy for current value.

For land and building assets, professional valuations are carried out by Newmark. The valuations have been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant Department of Health and Social Care Group Accounting Manual. They are also prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: Valuation - Global Standards (December 2024 edition).

The valuation basis for the Trust's land and building assets is that of an alternative site basis. In selecting the alternative site on which the modern equivalent asset would be situated, the Valuer, in discussion with the Trust, considers whether the actual site remains appropriate for use by the Trust, in accordance with section 7 of UK GN on DRC. For public sector bodies, HM Treasury guidance is that the choice of whether to value an alternative site will normally hinge on whether the proposed alternative site will meet the locational requirements of the service that is being provided.

A full valuation of land and buildings was prepared by Newmark as at 31 March 2025. This was predominantly performed on a desktop basis with the exception of the newly constructed elective orthopaedic centre and urgent treatment centre which received an initial full valuation upon being brought into operational use for the first time. Where required, site inspections were undertaken during the year and additional work was undertaken to review building plans and re-validate GIA data. This resulted in a downward revaluation of buildings by £16.120m. £15.233m of this value was an impairment charged to operating expenses with the other £0.887m being a decrease to the revaluation reserve.

Valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value. In accordance with Treasury guidance, all revaluations undertaken since 1 May 2008 (Colchester) and 1 July 2018 (Ipswich) have been based on "modern equivalent assets".

Note 15 Leases – East Suffolk and North Essex NHS Foundation Trust as a Lessee

This note details information about leases for which the Trust is a lessee. These are predominantly property leases along with a smaller number of equipment and vehicle leases.

Note 15.1 Right-of-Use Assets – 2024/25

	Property (land & buildings)	Plant & machinery	Transport equipment	Total	Of which leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024	**76,267**	**8,378**	**778**	**85,423**	**52,850**
Additions	1,675	1,295	206	**3,176**	1,675
Remeasurements of the lease liability	3,941	11	-	**3,952**	3,164
Impairments charged to operating expenses [1]	(44,524)	-	-	**(44,524)**	(40,704)
Reversal of impairments	(21)	-	-	**(21)**	-
Revaluations	(22)	-	-	**(22)**	-
Disposals/derecognition	(1,864)	-	(123)	**(1,987)**	(1,491)
Reclassifications to property, plant and equipment	-	(3,058)	-	**(3,058)**	-
Valuation/gross cost at 31 March 2025	**35,452**	**6,626**	**861**	**42,939**	**15,494**
Accumulated depreciation at 1 April 2024	**14,303**	**7,241**	**322**	**21,866**	**12,071**
Provided during the year	8,421	497	268	**9,186**	6,547
Impairments charged to operating expenses	(15,953)	-	-	**(15,953)**	(14,947)
Reversal of impairments	(28)	-	-	**(28)**	-
Revaluations	(124)	-	-	**(124)**	-
Disposals/derecognition	(539)	-	(109)	**(648)**	(404)
Reclassifications to property, plant and equipment	-	(2,724)	-	**(2,724)**	-
Accumulated depreciation at 31 March 2025	**6,080**	**5,014**	**481**	**11,575**	**3,267**
Net book value at 31 March 2025	**29,372**	**1,612**	**380**	**31,364**	**12,227**
Net book value at 1 April 2024	**61,964**	**1,137**	**456**	**63,557**	**40,779**

1. In 2024/25 the Trust undertook a revaluation of right of use property leased assets (see note 1.18). A downward valuation specifically pertaining to three properties leased from Community Health Partnerships has resulted in a £28.1m impairment being recognised in operating expenses (Fryatt Hospital - £9.1m; Colchester Primary Care Centre - £16.5m; nuclear medicine - £2.5m).

Note 15.2 Right-of-Use Assets – 2023/24

	Property (land & buildings)	Plant & machinery	Transport equipment	Total	Of which leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023	**65,223**	**10,174**	**449**	**75,846**	**48,825**
Additions	5,010	-	329	**5,339**	-
Remeasurements of the lease liability	5,690	-	-	**5,690**	4,752
Impairments	(54)	-	-	**(54)**	-
Revaluations	1,125	-	-	**1,125**	-
Disposals/derecognition	(727)	(1,796)	-	**(2,523)**	(727)
Valuation/gross cost at 31 March 2024	**76,267**	**8,378**	**778**	**85,423**	**52,850**
Accumulated depreciation at 1 April 2023	**6,703**	**7,974**	**74**	**14,751**	**5,814**
Provided during the year	7,936	1,063	248	**9,247**	6,337
Impairments	(36)			**(36)**	
Revaluations	(220)	-	-	**(220)**	-
Disposals/derecognition	(80)	(1,796)	-	**(1,876)**	(80)
Accumulated depreciation at 31 March 2024	**14,303**	**7,241**	**322**	**21,866**	**12,071**
Net book value at 31 March 2024	**61,964**	**1,137**	**456**	**63,557**	**40,779**
Net book value at 1 April 2023	**58,520**	**2,200**	**375**	**61,095**	**43,011**

Note 15.3 Revaluation of the Carrying Value of Lease Liabilities

For right-of-use assets accounted for under IFRS 16, lease liabilities are revalued based on changes to the value of the future minimum lease payments due under the lease contract. Lease liabilities are initially measured using the interest rate implicit in the lease or the HM Treasury incremental borrowing rate in the absence of an implicit rate. Where changes in the future lease payments result from a change in index or rent review, the borrowing rate used for the calculation of the original lease liability is retained. For leases commencing in the 2024 calendar year under IFRS 16 the HM Treasury borrowing rate was 4.72%, and for the 2025 calendar year it was increased to 4.81%. However, where future lease payments are changed as a result of a lease modification, e.g. a change in lease term or increase/decrease in leased property space, the borrowing rate in effect at that time is used.

Note 15.4 Reconciliation of the Carrying Value of Lease Liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 20.1.

	2024/25 £000	2023/24 £000
Carrying value at 1 April	**65,387**	**65,068**
Lease additions	3,176	5,339
Lease liability measurements	3,952	5,690
Interest charge arising in year	973	1,000
Early terminations	(1,555)	(723)
Lease payments (cash outflows)	(11,780)	(10,987)
Carrying value at 31 March	**60,153**	**65,387**

Lease payments for short term leases were a credit of £8k in 2024/25 and are recognised in operating expenditure.

These payments are disclosed at note 7. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 15.5 Maturity Analysis of Future Lease Payments at 31 March 2025

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
not later than one year;	9,212	6,374	10,115	6,582
later than one year and not later than five years;	34,823	26,077	34,323	24,462
later than five years.	26,232	8,524	29,586	11,540
Total gross future lease payments	**70,267**	**40,975**	**74,024**	**42,584**
Finance charges allocated to future periods	(10,114)	(2,810)	(8,637)	(1,448)
Net lease liabilities at 31 March 2025	**60,153**	**38,165**	**65,387**	**41,136**

Note 16 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	6,840	6,304
Consumables	10,360	8,388
Energy	139	125
Total inventories	**17,339**	**14,817**

Inventories recognised in expenses for the year were £73,766k (2023/24: £59,743k).
Write-down of inventories recognised as expenses for the year were £516k (2023/24: £166k).

Note 17 Receivables

Note 17.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	17,775	22,222
Allowance for impaired contract receivables/assets	(2,198)	(1,751)
Prepayments (non-PFI)	13,441	7,591
PFI lifecycle prepayments	3,059	1,891
Interest receivable	244	279
Operating lease receivables	230	172
PDC dividend receivable	854	467
VAT receivable	4,107	2,635
Clinician pension tax provision reimbursement funding from NHSE	36	28
Total current receivables	**37,548**	**33,534**
Non-current		
Contract receivables	1,844	1,651
Allowance for impaired contract receivables	(451)	(380)
Clinician pension tax provision reimbursement funding from NHSE	867	862
Total non-current receivables	**2,260**	**2,133**
Of which receivable from NHS and DHSC group bodies:		
Current	9,057	12,644
Non-current	867	862

Note 17.2 Exposure to Credit Risk

The Trust has no significant exposure to credit risk as the majority of the Trust's revenue comes from contracts with other NHS bodies.

Note 18 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.

	2024/25 £000	2023/24 £000
At 1 April	**79,254**	**75,137**
Net change in year	(17,078)	4,117
At 31 March	**62,176**	**79,254**
Broken down into:		
Cash at commercial banks and in hand	26	24
Cash with the Government Banking Service	62,150	79,230
Total cash and cash equivalents as in SoFP	**62,176**	**79,254**

Note 19 Trade and Other Payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	31,898	19,696
Capital payables	27,128	47,786
Accruals	36,294	41,469
Social security costs	4,918	4,287
Other taxes payable	9,727	8,721
Pension contributions payable	8,721	7,599
Total current trade and other payables	**118,686**	**129,558**
Of which payables from NHS and DHSC group bodies:		
Current	3,421	5,745

Note 20 Borrowings and Financing

Note 20.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	1,195	1,196
Other loans	60	114
Lease liabilities	7,889	9,164
Obligations under PFI or other service concession contracts	1,740	1,902
Total current borrowings	**10,884**	**12,376**
Non-current		
Loans from DHSC	8,338	9,526
Other loans	-	60
Lease liabilities	52,264	56,223
Obligations under PFI or other service concession contracts	27,284	27,599
Total non-current borrowings	**87,886**	**93,408**

Note 20.2 Reconciliation of Liabilities Arising from Financing Activities - 2024/25

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI schemes £000	Total £000
Carrying value at 1 April 2024	**10,722**	**174**	**65,387**	**29,501**	**105,784**
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,188)	(114)	(10,797)	(1,888)	**(13,987)**
Financing cash flows - payments of interest	(227)	-	(983)	(1,195)	**(2,405)**
Non-cash movements:					
Additions	-	-	3,176	-	**3,176**
Lease liability remeasurements	-	-	3,952	-	**3,952**
Remeasurement of PFI liability resulting from change in rate	-	-	-	1,507	**1,507**
Interest charge arising in year	226	-	973	1,099	**2,298**
Early terminations	-	-	(1,555)	-	**(1,555)**
Carrying value at 31 March 2025	**9,533**	**60**	**60,153**	**29,024**	**98,770**

Note 20.3 Reconciliation of Liabilities Arising from Financing Activities - 2023/24

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI schemes £000	Total £000
Carrying value at 1 April 2023	**11,910**	**314**	**65,069**	**16,033**	**93,326**
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,188)	(140)	(10,013)	(2,250)	**(13,591)**
Financing cash flows - payments of interest	(253)	-	(974)	(1,038)	**(2,265)**
Non-cash movements:					
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	11,872	**11,872**
Additions	-	-	5,339	-	**5,339**
Lease liability remeasurements	-	-	5,690	-	**5,690**
Remeasurement of PFI liability resulting from change in rate	-	-	-	3,751	**3,751**
Application of effective interest rate	253	-	1,000	1,133	**2,386**
Early terminations	-	-	(723)	-	**(723)**
Carrying value at 31 March 2024	**10,722**	**174**	**65,387**	**29,501**	**105,784**

Note 21 Provisions for Liabilities

Note 21.1 Provisions for Liabilities and Charges Analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other [1]	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2024	**80**	**755**	**59**	**-**	**5,267**	**6,161**
Change in the discount rate	-	2	-	-	(8)	**(6)**
Arising during the year	5	52	49	87	339	**532**
Utilised during the year	(48)	(79)	(27)	-	(2,519)	**(2,673)**
Reversed unused	-	(1)	(5)	-	-	**(6)**
Unwinding of discount	4	17	-	-	44	**65**
At 31 March 2025	**41**	**746**	**76**	**87**	**3,123**	**4,073**
Expected timing of cash flows:						
not later than one year;	20	80	76	87	1,486	**1,749**
later than one year and not later than five years	21	295	-	-	851	**1,167**
later than five years	-	371	-	-	786	**1,157**
Total	**41**	**746**	**76**	**87**	**3,123**	**4,073**

1. Within the "other" category is an amount of £903k relating to clinicians' pension tax. Trusts are required to apply paragraph 54 of IAS 37 and offset income to be reimbursed against this expenditure by the Department of Health and Social Care (see note 17.1). Therefore, no costs are reflected in operating expenditure for this provision decrease.

Pensions
Relates to sums payable to former employees having retired prematurely from work. The outstanding liability is based upon current and expected benefits advised by the NHS Pensions Agency and the computed life expectancies of pension recipients.

Legal Claims
Based upon professional assessments which are uncertain to the extent that they are an estimate of the likely outcome of individual cases. Due dates of settlement of claims are based upon estimates supplied by NHS Resolution and/or legal advisers.

Other
The Trust has recognised a provision, broadly equal to the tax charge, for clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in the tax year 2019/20, and only in that year, face a tax charge in respect of the growth of their NHS pension benefits. This is offset by a commitment from NHS England and the Government to fund the payments to clinicians as and when they arise. The provision and offsetting asset will initially increase year on year in line with the pension scheme growth and be released as commitments are met.

A further provision is recognised for an onerous contract relating to the biofuel energy centre. This recognises the future interest charges due over the life of the financing arrangement but where no economic benefit is being received from the centre.

Note 21.2 Clinical Negligence Liabilities

At 31 March 2025, £348,913k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East Suffolk and North Essex NHS Foundation Trust (31 March 2024: £356,484k).

Note 22 Contractual Capital Commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	22,928	17,267
Intangible assets	316	32
Total	**23,244**	**17,299**

Note 23 On-SoFP PFI Arrangements

Note 23.1 On-SoFP PFI Obligations

The Trust has two PFI schemes recognised on SoFP. The first is the Garrett Anderson Centre at Ipswich Hospital and the figures reported below relate solely to this scheme.

The Trust's other PFI arrangement for staff accommodation is accounted for as a service concession, in accordance with IFRIC 12. The service operator receives all of its income from individual users rather than in the form of unitary payments from the Trust. As such there is no service charge but the asset is recognised under non-current assets on the Statement of Financial Position with a corresponding deferred income liability.

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2025 £000	31 March 2024 £000
Gross PFI liabilities	**36,110**	**37,284**
Of which liabilities are due:		
not later than one year;	2,779	2,949
later than one year and not later than five years;	11,801	10,897
later than five years.	21,530	23,438
Finance charges allocated to future periods	(7,086)	(7,783)
Net PFI obligation	**29,024**	**29,501**
not later than one year;	1,740	1,902
later than one year and not later than five years;	8,303	7,308
later than five years.	18,981	20,291

Note 23.2 Total on-SoFP PFI Commitments

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

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI arrangements	**60,630**	**62,896**
Of which payments are due:		
not later than one year;	5,512	5,241
later than one year and not later than five years;	22,047	20,965
later than five years.	33,071	36,690

Note 23.3 Analysis of Amounts Payable to PFI Operator

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

	2024/25 £000	2023/24 £000
Unitary payment payable to PFI operator	**5,510**	**4,929**
Consisting of:		
Interest charge	1,099	1,133
Repayment of balance sheet obligation	1,680	2,458
Service element and other charges to operating expenditure	1,121	755
Addition to lifecycle prepayment	1,610	583
Other amounts paid to operator due to a commitment under the PFI contract but not part of the unitary payment	67	119
Total amount paid to PFI operator	**5,577**	**5,048**

Note 24 Financial Instruments

Note 24.1 Financial Risk Management

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

Financial Risk Management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is routinely reported and is subject to review by the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. As such, the Trust does not undertake transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. The Trust has no overseas operations.

Credit Risk

As the majority of the Trust's revenue comes from contracts with other NHS bodies, the majority of the Trust's customers are integrated care boards, NHS providers and NHS England. As such, credit risk in this area is considered to be linked to disputes over activity rather than the customers' ability to pay. Other potential customers may be subject to an appropriate credit check or restricted credit limit before activity is undertaken (where clinical priorities allow). Where debtors exceed any agreed credit terms appropriate provision is made against that class of debt. Therefore, the Trust considers that it has a low exposure to credit risk.

Liquidity Risk

The Trust's net operating costs are incurred under annual service contracts with local integrated care boards, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Interest Rate Risk

The Trust borrows from Government for capital expenditure subject to affordability. The borrowings are for 1-25 years, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Note 24.2 Carrying Values of Financial Assets

	31 March 2025 Held at amortised cost £000	31 March 2024 Held at amortised cost £000
Trade and other receivables excluding non-financial assets	18,346	23,082
Cash and cash equivalents	62,176	79,254
Total	**80,522**	**102,336**

Note 24.3 Carrying Values of Financial Liabilities

	31 March 2025 Held at amortised cost £000	31 March 2024 Held at amortised cost £000
Loans from the Department of Health and Social Care	9,533	10,722
Obligations under finance leases	60,153	65,387
Obligations under PFI and other service concession contracts	29,024	29,501
Other borrowings	60	174
Provisions	1,073	1,415
Trade and other payables excluding non-financial liabilities	89,436	113,607
Total	**189,279**	**220,806**

Note 24.4 Maturity of Financial Liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	103,186	128,550
In more than one year but not more than five years	52,652	51,612
In more than five years	51,520	58,169
Total	**207,358**	**238,331**

Note 24.5 Fair Value of Financial Assets and Liabilities

As at 31 March 2025 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

Note 25 Losses and Special Payments

	2024/25		2023/24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	18	22	22	45
Fruitless payments and constructive losses[1]	1	388	-	-
Bad debts and claims abandoned	13	17	27	67
Stores losses and damage to property	3	372	3	155
Total losses	**35**	**799**	**52**	**267**
Special payments				
Ex-gratia payments	60	92	70	61
Total special payments	**60**	**92**	**70**	**61**
Total losses and special payments	**95**	**891**	**122**	**328**

1. In 2024/25 the Trust recognised a fruitless payment of £387,580 for the write-off of its Clinical Record Interactive Search (CRIS) system. This was procured in 2022/23 as an intangible software asset, but implementation was delayed for a range of operational reasons. In 2024/25 the Trust incorporated the functionality of the CRIS system into the development of its new electronic patient record system rendering the existing software obsolete.

Note 26 Related Parties

Members of the governing body are required to declare any interests that they hold, either directly or through close family members, in organisations other than the Trust. Where the Trust incurs expenditure with or receives income from those organisations, the organisations are known as related parties and the transactions must be reported.

During the period, none of the members of the Board of Directors or Board of Governors, or parties related to them, have undertaken any material transactions with the Trust.

Department of Health and Social Care Group Bodies

NHS foundation trusts are deemed to be under the control of the Secretary of State, in common with other NHS entities, including NHS trusts, NHS England and integrated care boards. The Department of Health and Social Care is considered to be the Trust's parent organisation and other NHS bodies are therefore classed as related parties. During the financial period, the Trust had a number of material transactions with NHS bodies, all of which were at arm's length. None of the Trust's balances with related parties are held under security or guarantee.

As per paragraph 5.248 – 5.253 of the Department of Health and Social Care Group Accounting Manual, no transactions are required to be disclosed for such bodies. NHS entities with whom the Trust has had material transactions, greater than £6.1m (2023/24, £5.3m) (0.5% of Trust income), are shown below:

2024/25	**2023/24**
Community Health Partnerships	Community Health Partnerships
NHS England	NHS England
NHS Mid and South Essex ICB	NHS Mid and South Essex ICB
NHS Resolution	NHS Resolution
NHS Suffolk and North East Essex ICB	NHS Suffolk and North East Essex ICB
-----	NHS Property Services
West Suffolk NHS Foundation Trust	West Suffolk NHS Foundation Trust

Other Government Organisations

The Trust has had a number of material transactions greater than £6.1m (2023/24, £5.3m) with other government departments and other central and local government bodies during the year:

	2024/25 Expenditure £000	2024/25 Income £000	2024/25 Payables £000	2024/25 Receivables £000
HMRC	56,959	-	14,645	-
NHS Pension Scheme	99,939	-	8,721	-
NHS Professionals	50,338	-	7,931	-

	2023/24 Expenditure £000	2023/24 Income £000	2023/24 Payables £000	2023/24 Receivables £000
HMRC	52,140	-	13,008	-
NHS Pension Scheme	78,101	-	7,599	-
NHS Professionals	50,690	-	7,966	-

Trust Affiliates

	2024/25 Expenditure £000	2024/25 Income £000	2024/25 Payables £000	2024/25 Receivables £000
The Colchester and Ipswich Hospitals Charity[1]	-	2,585	-	24
Norfolk and Norwich University Hospitals NHS Foundation Trust[2]	350	2,821	569	222

	2023/24 Expenditure £000	2023/24 Income £000	2023/24 Payables £000	2023/24 Receivables £000
The Colchester and Ipswich Hospitals Charity[1]	-	1,118	-	54
Norfolk and Norwich University Hospitals NHS Foundation Trust[2]	985	2,372	528	509

Notes:

	Related Party	Relationship and Interest
1.	The Colchester and Ipswich Hospitals Charity	The Board of East Suffolk and North Essex NHS Foundation Trust is the Corporate Trustee of the Charity. (Income includes donated assets, cash donations towards capital expenditure and contributions to staffing costs, along with direct charitable expenditure for staff and patient welfare.
2.	Norfolk and Norwich University Hospitals NHS Foundation Trust	Due to the secondment of the Board positions of Chief Executive and Chief Medical Officer during the reporting period.

Note 27 Events after the Reporting Date

The financial statements were authorised for issue by the Trust Board on 26 June 2025. There were no events after the reporting date which are required to be disclosed in the financial statements in the current year.