

Annual report 2017-18

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Performance report: our year

Welcome to our Annual Report 2017-18 – we are pleased to share with you our achievements and update you on our plans, our performance and the difference our people continue to make to our patients.

Foreword

The ongoing high demand on NHS services across the country has been well-documented during 2017-18 and, across SASH, we have continued to see unprecedented demands on all our services. At times, this national situation has resulted in negative stories in the national and local media that have often appeared to overlook just how hard NHS staff work to provide the very best care for patients.

We know just how hard everyone at SASH has continued to work. The enormous effort, commitment and dedication shown by everyone, both our frontline teams and also all those who work behind the scenes to support the clinical teams caring for patients, has been extraordinary and is a one team approach that we are immensely proud of.

Of course this high demand has also impacted on our local health and social care system partners too and we continue to work with them to build on our partnership approach to ensure that we all focus on delivering high quality and safe care. We continue to play our part in making a difference to the people we care for and we see in the feedback and letters we receive just how much this care is valued and appreciated by our patients.

Although the impact of this high demand should not be underestimated we are pleased that we continue to receive such positive comments and feedback from our patients and their relatives about the compassion they have been shown and the high quality care they have received.

We are delighted that this positive culture was reflected in the results of the annual national NHS Staff Survey that saw our staff rank SASH amongst the best - putting us fourth in the country and in the top 20 per cent of hospitals nationally as a place to work and receive treatment and also as somewhere patients receive quality treatment and care. They also rated us first in the country for recognition and value of staff; good communication; support from immediate managers and quality of

appraisals. It is great to know how positive our staff feel about working at SASH and the strong link with this and the quality of care they know they are able to provide. Of course, not only is this important for everyone at SASH it is especially important for our patients and the people we care for. We are concerned that in two areas we are in the lowest 20 percent for staff experiencing physical violence and harassment, bullying or abuse from patients, relatives or the public. We have action plans in place to focus on these issues and make improvements.

In 2017-18 we have continued to develop and improve the services we provide to local people. This has included the move of our ambulatory care service to the new Kingsfold Unit, that takes emergency care referrals directly from local GPs and can support the care of up to 23 patients at any one time. From its first week the Kingsfold Unit has had a positive impact on ensuring that our patients get the right care in the right place, first time, and this includes the time for a full assessment and treatment that usually means a patient is able to go home the same day.

By reconfiguring some existing rooms we also created a tailor-made space for a Surgery Centre at East Surrey Hospital for day surgery patients. We were pleased to welcome the Rt Hon Professor Lord Kakkar PC, a leading surgeon in the field of thromboembolic disease and cancer-associated thrombosis, to open the Centre in September 2017. We anticipate that over 10,000 patients a year will be cared for by the Surgery Centre team, both as day cases and appointments.

Our SASH+ transformation work, in partnership with NHS Improvement and the Virginia Mason Institute continues to be embedded and with more and more staff completing the Lean for Leaders training programme that provides staff from across SASH with the lean tools for change we are seeing real change in the way we do things at SASH. Many of the improvements are seemingly simple yet the difference they make can be measured and, most importantly, shared across SASH for the benefit of our patients. A fact that Jeremy Hunt, Secretary of State for Health and Social Care rated highly during his visit to SASH in February this year (2018).

We see high quality care delivered across SASH and we are pleased that we continue to play a significant part in a large number of clinical trials research that will see new treatments and drugs developed for patients. We are delighted that the work of our research and development team was recognised by the National Institute for Health Research who awarded them as joint partnership winners in the Best contribution to commercial research category of the CRN KSS (Kent, Surrey and Sussex) Partnership Awards 2018 along with colleagues from Ashford and St Peter's Hospitals NHS Foundation Trust.

Further recognition of quality care at SASH has seen the East Surrey Macmillan Cancer Support Centre achieve the Cancer Environment and Macmillan Quality in Information and Support Services Quality Standards. This is great recognition of the

hard work of the Centre team in ensuring a quality environment for patients and visitors along with the team of volunteers, including complementary therapists, who all provide support for patients and local people living with cancer.

We are delighted that the Trust has accomplished the first aim of our medium-term financial strategy and that we are in surplus at the start of 2018-19. This achievement is an important foundation for our overall clinical sustainability.

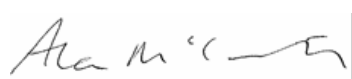
However well we are performing we recognise there is still much to do and that on occasion we do not get it right for some patients. We will continue to strive to ensure that every patient gets the very best care.

Also, as we look to the future a key target for us is to be a sustainable organisation - our action plan will put in place the steps we need to take to deliver care without carbon and put sustainability at the core of our activities.

We have been pleased to meet many patients, governors, members and local people at our ongoing series of Hot Topic events. Held across the year the events are hosted by one of our specialist teams who provide and insight into the care they provide. We hope to see you at a Hot Topic event in 2018-19.

We are immensely proud of everything that SASH has been able to achieve this year and we know that each achievement and success is only made possible by the hard work, commitment and compassion of our clinicians, staff and volunteers. We thank them all; for everything that they do each and every day.

Thank you.



Alan McCarthy
Chair



Michael Wilson CBE
Chief executive

Overview

About us

Surrey and Sussex Healthcare NHS Trust (SASH) provides acute and complex services at East Surrey Hospital in Redhill alongside a range of outpatient, diagnostic and planned care at Caterham Dene Hospital, The Earlswood Centre and Oxted Health Centre in Surrey and at Crawley and Horsham Hospitals in West Sussex.

Serving a growing population of over 535,000 we care for people living, working and visiting east Surrey, north-east West Sussex, and south Croydon, including the towns of Crawley; Horsham; Reigate and Redhill.

East Surrey Hospital is the designated hospital for Gatwick Airport and sections of the M25 and M23 motorways. It has a trauma unit, which cares for seriously injured patients in partnership with the major trauma centres at St George's University Hospitals NHS Foundation Trust, Tooting, and Royal Sussex County Hospital, Brighton. East Surrey Hospital has 697 beds and ten operating theatres, along with four more theatres at Crawley Hospital in a day surgery unit.

We are a major local employer, with a diverse workforce of over 4,200 providing healthcare services to the communities we serve.

The Trust is an Associated University Hospital of Brighton and Sussex Medical School and we are part of educating cohorts of final year medical students from the school each year under the supervision of one of our consultants. Our involvement supports the medical workforce of the future and the delivery of high quality patient care.



Population of
535,000

4,215
staff

697
beds

14
operating
theatres



- East Surrey Hospital, Redhill
- Caterham Dene Hospital
- Oxted Health Centre
- Earlswood Centre
- Crawley Hospital
- Horsham Hospital

Our vision

We will pursue perfection in the delivery of safe, high quality healthcare that puts the people in our community first.

Our values

Dignity and respect: we value each person as an individual and will challenge disrespectful and inappropriate behaviour.

One team: we work together and have a 'can do' approach to all that we do recognising that we all add value with equal worth.

Compassion: we respond with humanity and kindness and search for things we can do, however small; we do not wait to be asked, because we care

Safety and quality: we take responsibility for our actions decisions and behaviours in delivering safe, high quality care

The services we provide are commissioned by local clinical commissioning groups (CCGs) as well as NHS England.

Clinically- led

We are a clinically led organisation, focused on putting people first. Our services are led and managed through four divisions:

	Cancer and diagnostics	Medicine	Surgery	Women and children
Chief	Dr Edward Cetti	Dr Ben Mearns	Dr Barbara Bray	Dr Zara Nadim
Associate director	Jane Griffiths	Alison James	Natasha Hare	Bill Kilvington
Divisional Chief nurse	Victoria Daley	Nicola Shopland	Jamie Moore	Michelle Cudjoe (Head of midwifery)

Our governors and members

The Trust Board made the decision to recruit a patient and public members and elect a council of governors as part of its final stages of preparation on the aspirant foundation Trust pipeline. The Council of Governors remains constituted however it does not have equivalent responsibilities to a similar body for a Foundation Trust.

Our governors have an important role to play and make a contribution to how we deliver services and they have become a trusted group of critical friends. The Trust aspires to facilitate our governors to make a real contribution to how we deliver services and make a difference to the future health and wellbeing of local people. Governors work with, and represent, the members of their constituencies by shaping the mind-set of the Trust towards the needs and experience of patients and local people; in effect, by making sure 'patients are always in the room' when services are being discussed and decisions made.

The governors are elected by members of the constituency of which they are a member and which they represent. The Council of Governors include elected public governors and staff governors and nominated governors from partner organisations. Our governors are volunteers and unpaid, and Council of Governors meetings which are held four times a year. Governors are also members of sub-group meetings, on specific issues, for example patient experience and community engagement events as well being part of our annual general meeting which is held each September. In January 2018 the role of co-ordinating governor was introduced and the Council of Governors voted for two members to share this role.

Governors provide valuable insight and feedback from the members they represent.

The Trust has around 10,000 members, 6,000 from its patient and public constituencies and 4,000 from its staff. The membership constituencies are:

- Reigate and Banstead
- Tandridge
- Crawley
- Horsham
- Mole Valley
- Mid Sussex
- Croydon (electoral wards: Purley; Coulsdon East; Coulsdon West; Kenley; Sanderstead)
- Patients from outside the catchment area
- SASH staff

This year our governors have played an active and important role in:

- ☐ Annual environmental assessments
- ☐ Wayfinding hospital signage project

- ☐ Hand hygiene awareness days
- ☐ Ward and departmental visits
- ☐ Organ donation committee
- ☐ Development of our patient and public engagement strategy

Our Governors:

- ☐ **Have input into Trust strategy development**
- ☐ **Have an active role in the improvement work for the Trust**
- ☐ **Support the Trust in public consultations**
- ☐ **Are members of key patient focused working groups**
- ☐ **Are fundraising champions**
- ☐ **Advise on patient information development**
- ☐ **Will be consulted by CQC as part of their formal inspection programme**
- ☐ **Continue to be a resource and sounding board for the Trust**

Our clinical commissioning groups (CCGs)

The services we provide are commissioned by local clinical commissioning groups (CCGs) as well as NHS England.

In 2017-18, we held contracts with 11 CCGs; our co-ordinating commissioner for the Sussex contract is Crawley CCG with ten associates.

The Trust has a contract with NHS England, who commission specialised services and secondary care dental. The Trust also has a contract with Sussex MSK (musculoskeletal) which is a partnership hosted by a limited company. The majority of our services are commissioned by:

- **East Surrey CCG:** has 18 GP practices covering the districts of Tandridge, Redhill, Reigate and Horley with a population of just under 178,000 people
- **NHS Surrey Downs CCG:** has 32 GP practices serving a population of over 300,000 people living in Mole Valley, Epsom and Ewell, Banstead and east Elmbridge
- **Crawley CCG:** has 12 GP practices covering the Crawley district with a population of over 129,000 people

- **Horsham and Mid Sussex CCG:** has 23 GP practices covering the northern part of Horsham District and Mid Sussex District with a population of more than 231,000 people

Our CQC rating

The Trust was rated 'good' overall by the Care Quality Commission (CQC) in its Chief Inspector of Hospitals inspection in August 2014. The Trust has received no further inspections in 2017-18 and no formal concerns have been raised by the CQC.

All inspected services were rated as good in the caring domain with end of life care receiving an outstanding rating for responsiveness. This was a significant milestone for the Trust and the inspection team commented that the culture and engagement in the organisation was excellent.

At that time the outpatient service was rated as requires improvement and the Trust was required to implement a number of actions. In January 2016, the CQC carried out a focused follow-up inspection of outpatients and confirmed that the Trust had met the required regulations. No 'must do' recommendations were identified and the Trust were given six 'should do' recommendations. The report was published at the end of March 2016. The Trust continues on its journey to become an 'outstanding' organisation.



Our health campus

We have a proud history of working in partnership with other Trusts and organisations to provide specialist care to local people; closer to home. Our health campus at East Surrey Hospital includes the:

- St Luke's Radiotherapy Cancer Centre, a partnership with the Royal Surrey County Hospital Cancer Centre
- Lane Fox REMEO Respiratory Centre, a partnership with Guy's and St Thomas's NHS Foundation Trust
- East Surrey Macmillan Cancer Support Centre, a partnership with Macmillan Cancer Support



Putting people first
Delivering excellent, accessible healthcare

SASH+ - transforming care

In March 2015, the NHS Trust Development Authority, now part of NHS Improvement, invited expressions of interest from NHS Trusts to be part of a five year development partnership, which aims to fundamentally improve the quality, performance and financial sustainability of the organisations selected to take part as well as share learning with others.

Over the last two years SASH, along with four other Trusts have been working in partnership with the Virginia Mason Institute (VMI) in Seattle, USA who have developed a transformational management system - the Virginia Mason Production System, which is based on lean methodological improvement techniques adopted and adapted from the Toyota car manufacturing factory in Japan. Over the last 17 years the Virginia Mason Production System has enabled them to become one of the safest and highest rated hospital organisations in the USA.

Reflecting the Japanese history of the programme some of the references and language used are Japanese in origin, for example:

Kaizen

Continuous incremental improvement

Genba

Where the work is done

Our aim at SASH is to pursue perfection, putting our patients at the forefront of everything we do, improving safety and quality by reducing variation and waste in every process. Our SASH+ work supports an accelerated transformation in quality by providing us with a structured approach to continue our improvement journey taking us from a good to an outstanding organisation.

SASH has a Trust Guiding Team (TGT) which meets monthly and is responsible for oversight and delivery of the improvement work. Led by the chief executive, the TGT has strong clinical leadership involvement – membership of the TGT includes senior clinicians and executives.

Our kaizen promotion office (KPO) team lead the transformation programme; providing the structure, methods and rigor behind the successful implementation of the SASH+ improvement methodology, alongside training and developing staff from across the organisation to lead using the new methods.

Over the last year, the SASH+ work has continued within three value streams (workstreams), which have been specifically selected to help deliver the organisation's priorities, they are:

Inpatient flow: cardiology

This value stream starts from when the patient is referred to the cardiology team and ends when the patient is discharged or transferred from the cardiology ward.

Outpatients

This value stream starts from when the decision to refer for an outpatient appointment is made, usually in primary care and ends when the patient has attended their first follow-up appointment or been discharged (whichever is sooner).

Management of diarrhoea

This value stream starts at the onset of symptoms and ends when symptoms have resolved.

The addition of a fourth value stream focussing on patient discharge is planned for later in 2018.

Value stream sponsorship team

Each of the value streams has a value stream sponsorship team (VSST) consisting of senior clinical and non-clinical leaders from across the Trust. The sponsorship team is led by an executive sponsor who is a member of the TGT.

The role of the VSST is to lead the work of each value stream by:

- ☐ setting high level metrics through which progress can be monitored
- ☐ developing a kaizen plan which includes identifying and prioritising specific processes within the value stream which would benefit from a Rapid Process Improvement Workshop

Rapid Process Improvement Workshop

A Rapid Process Improvement Workshop (RPIW) is a five day event focused on a particular process, within a value stream, in which a multidisciplinary team of staff who do the work come together, empowered to improve the work flow and patient care. To ensure the perspective of the patient remains the priority during each workshop, patient representatives are invited to become a team member for the week working in partnership with staff to redesign processes.

Prior to each RPIW an extensive planning period is undertaken, which involves:

- selecting a sponsor (a member of the VSST) whose role it is to guide the work
- data collection on the genba so that a current state value stream map can be built (a value stream map is a visual tool which illustrates the flow of a specific process)

- selecting baseline metrics, which can be measured during the RPIW week and again at 30,60 and 90 days following the workshop to assess the effects of changes implemented
- identifying a process owner whose role it is to prepare the home team, these are the staff who are not members of the RPIW team but whose work is affected by the changes; they are encouraged to participate by providing ideas and feedback during event planning, the RPIW itself and during the implementation phase. The process owner is also responsible for implementation of changes trialled during the RPIW and re-measure of the metrics

At the end of every RPIW the RPIW team present their successes, challenges and learning to staff from across the Trust. This is known as a report out.

A total of six RPIWs were undertaken in 2017-18 focussing on a variety of different processes across the Trust including:

Cardiology value stream:

- ☐ inpatient referral to the cardiology team
- ☐ discharge from the cardiology ward
- ☐ inpatient angiography procedures
- ☐ booking process for cardiology procedures

Outpatient value stream:

- ☐ ophthalmology appointments
- ☐ breast clinic
- ☐ medical records preparation
- ☐ blood tests for patients attending rheumatology clinic
- ☐ role of the nurse

Management of diarrhoea value stream:

- ☐ identification and diagnosis of diarrhoea
- ☐ treatment of diarrhoea
- ☐ isolation for patients with diarrhoea
- ☐ stool sampling

Some of our key RPIW successes over the last year include:

Cardiology

- ☐ number of times the WHO checklist is completed in the catheter lab with all of team present has improved from 42% to 100%
- ☐ Safety huddles now take place at lunchtime and 4pm each day

- ☐ Patient leaflets being developed to inform patient the next steps in their pathway

Outpatients

- ☐ the number of steps walked by a patient attending the rheumatology clinic to have a blood test has reduced from 212 to 18
- ☐ the number of steps walked by a nurse to collect a gastric band deflation kit has reduced by 98% and from 13 minutes to 30 seconds

Management of diarrhoea

- ☐ the time it takes for patients requiring isolation to arrive in a side-room has reduced from 20 hrs and 30 mins to 4 hrs and 17 mins
- ☐ the number of patients with diarrhoea without a documented assessment for the need for isolation has reduced from 78% to 0%
- ☐ the number of patients who have not been asked if their bowels have been opened has reduced from 40% to 0%
- ☐ the number of samples received by the lab which are untestable has reduced from 33% to 21%

To continue our journey of improvement, RPIWs focussing on wide variety of processes across the Trust are planned on a six week basis for 2018-19.

Education and training

To share and embed a sustainable culture of continuous improvement across the Trust staff from 'Board to ward' are undertaking a variety of SASH+ training and development programs, including:

SASH+ taster and introduction sessions: These sessions have been developed for all staff to provide an overview of the SASH+ improvement methodology and to equip staff with some of the core tools and techniques that they are then able to apply on their genba to improve the services they deliver.

Lean for Leaders: A twelve month development programme which is aligned with the leadership objectives of the Trust's education and development strategy during which leaders from across the organisation learn about the SASH+ improvement methodology supported by an extensive range of tools and techniques, which help them to transform the services they deliver on a daily basis. The first two cohorts completed the course at the beginning of March 2017. There are a further four cohorts due to complete their training during 2018-19, this will take the total number of graduates from the program to over 200.

An example of the quality improvement staff undertaking the programme have implemented include:

Murali Bhat

Trauma and orthopaedic hand surgeon

Mr Bhat has implemented a rooming in process for hand surgery outpatients. This means that all patients are roomed in by trainees who complete all the relevant documentation and present the patient to the consultant who moves to each patient between rooms in turn

Now, all new outpatients have a consultant consultation and decisions agreed during their first appointment, which has resulted in increased patient satisfaction and a reduction in follow up appointments.

Murali now sees 30 rather than eight patients in each clinic - an increase of 74% in productivity and an improved experience for our patients.

Advanced Lean Training: An intensive learning experience which enables staff to deepen their knowledge of the SASH+ improvement methodology, refine their skills and build the capacity to teach, coach and mentor others in the tools and techniques. Two cohorts are due to complete this program in 2018-19.

Sharing our work

We have held a learning conference, three quarterly open days and hosted a number of additional visits which have provided a wide variety of stakeholders with the opportunity to see and experience, first-hand, the SASH+ transformation work that is taking place. They have been hugely impressed by the high levels of staff engagement and commitment to the work and the positive benefits the transformation programme is bringing to patients across the Trust.

We are on an exciting journey and we are very proud of the significant and sustainable transformation changes we have successfully made and look forward to continuing to improve the high quality of care we provide to local people. We are also proud of the empowering impact involvement in making change has on individuals and teams and feel that this is reflected how our staff rank the organisation in the national NHS Staff Survey.

'It's clear to see how much progress staff at SASH are making to improve safety and patient care through their renowned partnership with Virginia Mason. They have fantastic values - but what sets them apart is their measurement of these values which allows patients to see for themselves how the attitudes and ethos of staff directly improves the care they receive.'

Jeremy Hunt

Secretary of State for Health and Social Care

Research – improving care for patients

We undertake and support research that will improve healthcare in the future. Innovation in patient care is a Trust priority and involvement in clinical research is one way we can deliver excellent patient experiences and outcomes. Most of the national and international multi-centre studies, which we invite our patients to join, originate from the National Institute of Health Research (NIHR).

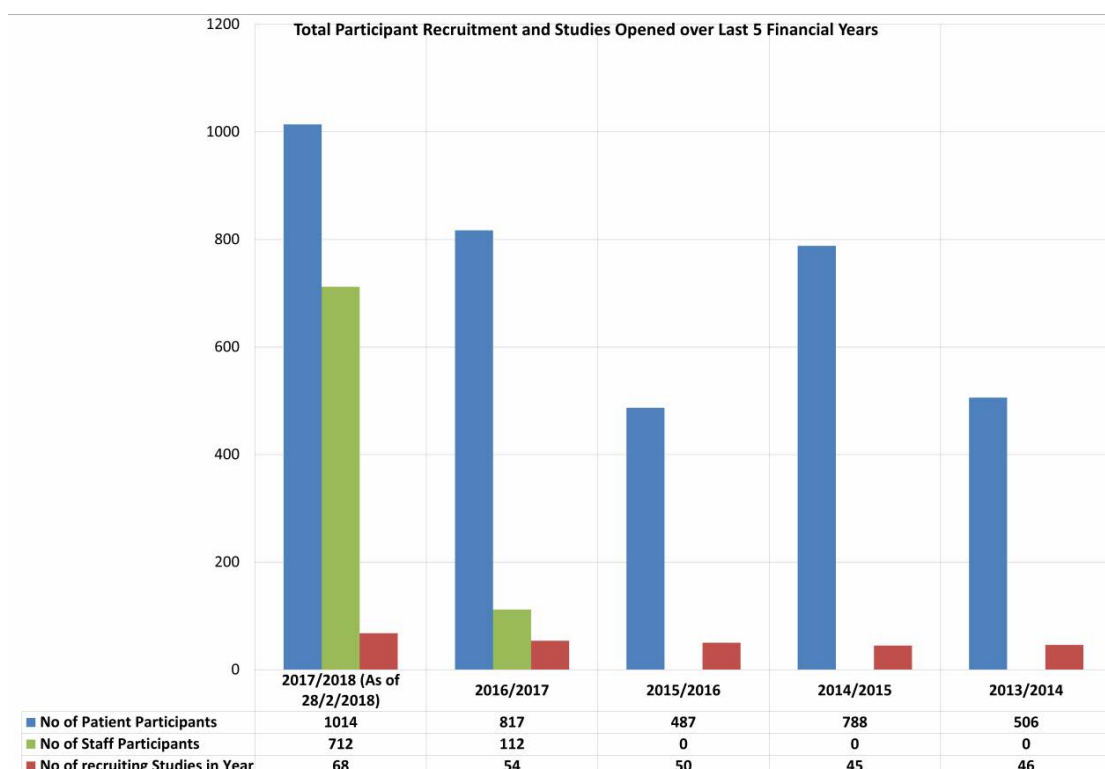
The research team supports clinical staff in making the most of any potential research opportunities and on the development of new research ideas which have the potential to improve patient care. Participation in multi-site research helps to ensure that our staff are aware of the latest treatment options and can offer our patients the best care available.

Recruitment performance and targets

Our aim is to support year-on-year growth in numbers of research studies open and number of patients recruited. In 2017-18 we delivered our strongest ever performance in research. Against a target of 800 patient recruits we were able to offer research participation to 1,077 of our patients into one of the 68 research projects which have run across the Trust in different disease areas or specialties.

We continue to perform well in respect of recruitment to research studies and in meeting national performance targets set for research. Our research department initiates prompt set up of new research studies, allowing us to achieve the first UK patient recruits and be amongst the top recruiting sites regionally and nationally for studies. We also continue to improve recruitment rates to studies, being one of the few organisations within our local research network to achieve 80% success rate in meeting recruitment targets for all studies. We have successfully recruited to time and target for all commercial clinical trials which finished recruiting in 2017-18.

Table: Patient recruitment - NIHR research studies



Patient experience

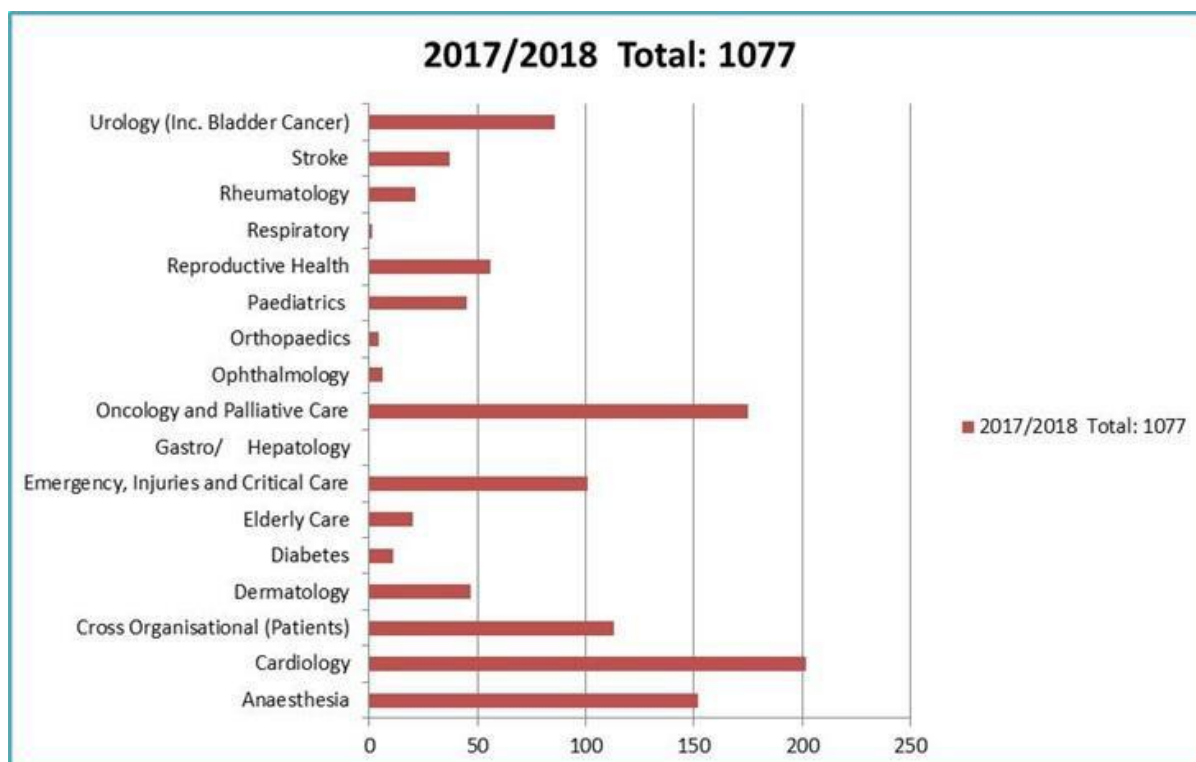
Our patients are keen to participate in clinical research and increasing clinician engagement in research has allowed us to offer participation across a wider range of services operating in our hospital.

Recruitment to research studies is the first step on the patient's research pathway. Research delivery teams consisting of principal and co-investigators; research nurses; co-ordinators and research administrators continue to support patients on follow up and continued treatment after they enter a study.

In 2017-18, there were more than 88 research studies actively recruiting patients or monitoring their long term follow up.

'I am in particular grateful for the attentive monitoring and I've learnt much about potential treatments and how I can do more myself.'

Table: Recruiting research studies across specialities



1,077 patients recruited to
68 different research studies



SASHCHARITY

SASH Charity

SASH Charity raises money to enhance the patient care provided at Surrey and Sussex Healthcare NHS Trust. The charity does this by investing in state-of-the-art equipment; improving the hospital environment; supporting ground-breaking health research and providing specialist training.

Putting people first
Delivering excellent, accessible healthcare



In 2017-18, the charity's income totalled £518,252.61 and it spent £184,997.24 in year. The closing balance, as at 31 March 2018, was £828,888.45.

The Charity Commission deadline for the submission of the charitable fund accounts for the year ended 31 March 2018 is 31 January 2019. Therefore, the accounts have not been finalised at this stage.

Fundraising activity

- SASH Charity was extremely grateful to receive two large legacy gifts from wills in 2017-18. These gifts will be carefully managed to ensure that these generous donations have the greatest impact on patient care
- A number of fundraisers took part in events for SASH Charity during the year. These included local man Mark Southam who ran the Brighton Marathon and raised over £700 for the chemotherapy department, who cared for two of his friends, which was put towards purchasing ocura trolleys
- Local student Sam Leah from Oakwood School in Horley raised nearly £900 for SASH Charity from a non- uniform day at his school. He has been receiving treatment at the orthoptic clinic at East Surrey Hospital for the past nine years
- In September 2017, SASH Charity launched its first fundraising campaign to raise £60k to create a purpose built dementia friendly garden for patients and their families at East Surrey Hospital. Fundraising for the garden is ongoing and work is due to begin in 2018
- At Christmas, bucket collections in Reigate High Street, Redhill station and The Belfry Shopping Centre made a total of £404 for SASH Charity

Making a difference

Donations to SASH Charity are used to go above and beyond the provision from the NHS. Money raised was used throughout the year to fund additional training for staff that enhances their specialist knowledge and skills to benefit the care provided at SASH.

SASH Charity funded an initiative to improve the nutritional intake of people living with dementia. An audit was carried out to test the theory that using blue plates instead of white plates would increase food consumption because the colour contrast makes the food more visible to patients with dementia.

'We found that patients with memory problems including dementia and temporary states such as a delirium ate more food when using the blue plates.'

We have had really positive results so far, and hope to extend the trial because a better diet will improve the health and wellbeing of our patients living with dementia.'

Chris O'Connor

Consultant admiral nurse

Another example of going above and beyond for SASH patients was the purchase of an outdoor gazebo for the chemotherapy suite. The gazebo provides a comfortable outdoor sitting area for patients undergoing chemotherapy treatment and their relatives to sit and relax outside of the suite. The gazebo also provides a place where patients can meet with a nurse if they are struggling with anxieties around entering the suite.

The Friends of East Surrey Hospital

The Friends of East Surrey Hospital

The aim of The Friends of East Surrey Hospital* charity is to supplement the service provided by the hospital for the comfort and welfare of patients, staff and visitors, by the provision of equipment and amenities and by supporting the voluntary work of the hospital.

The Friends of East Surrey Hospital have donated over £3.5m to the hospital since 1990

The Friends of East Surrey Hospital run a coffee shop in the east entrance of East Surrey Hospital. This is the main source of income for the charity and is run entirely by volunteers.

In 2016-17 The Friends of East Surrey Hospital made 26 grants to SASH totalling £156,000 including:

- ✓ £48,000 for a ward auditing system
- ✓ £45,000 for a patient communication and entertainment system for Kingsfold Ambulatory Care Unit, to provide free access to TV, radio, internet and telephone
- ✓ £182 to purchase two televisions for Bletchingly Ward.

Other grants were made to support the:

- ✓ hospital gardens
- ✓ floral arrangements for the hospital chapel
- ✓ the Sunshine Nursery annual outing
- ✓ bedside emergency response trolleys
- ✓ Christmas tea and coffee for ward staff

✓ Pictures for the maternity ward

*charity number 287535

Patient experience

What our patients say

The Trust launched an updated bespoke patient experience platform in March 2017. This web-based, specially designed system ensures that patient feedback is captured, analysed and shared at regular intervals and enables clinical areas to improve morale through the provision of positive feedback to staff and monitor trends. It also provides our patients with the option to request a call back from dedicated staff if they wish to discuss areas of concern further. Our surveys can be easily accessed online and staff are proactive in encouraging patients, family members and carers to provide feedback in order for us to improve our services.

It was recognised that other Trusts have improved the amount of completed surveys with the support of volunteers and by using electronic tablets. Our volunteers can now request patients, who are ready for discharge, to complete our surveys electronically and anonymously whilst still in the hospital. We are trialling this method in our emergency department (A&E) with a view to rolling this out to other areas where feedback is currently not obtained or very limited.

Our patient advice and liaison service (PALS) often receive feedback from patients which is shared with the relevant teams and we are also an active member of Care Opinion and monitor NHS Choices where patients can comment online about their experiences. We also have an express feedback function on our website so that people can provide free text comments quickly. This feedback is provided to the relevant teams in order for them, where possible, to affect change.

Care Opinion

The independent care opinion website continues to be an effective way of patients providing us with details of their interaction with us both positive and negative and having their voice heard within the Trust. Designated staff for each clinical area are responsible for responding to comments when they are posted and this works well within the organisation.

Patient Advice and Liaison Service (PALS)

Despite staffing issues throughout this year the PALS have had an average of over 300 contacts per month and continue to diffuse many situations and offer practical solutions and a listening ear in real time. They intervene so that potential reasons to complain can be managed proactively.

We have a new team in the PALS office and have taken the opportunity to evaluate the working processes. We have improved the environment and have drastically reduced the use of paper to log and manage concerns leading to greater efficiency.

The aim is for the PALS teams to become further integrated within our divisions and to attend governance meetings in order to share learning which has already started.

Your Care Matters

The FFT question is also embedded into all our bespoke Your Care Matters surveys and if a patient provides a negative score on this question an automated alert is generated which is provided to a pre-set distribution list of senior staff members. As mentioned above this also prompts the patient to provide their contact details so that senior staff can contact them to further explore the reasons behind the 'unlikely' or 'extremely unlikely response' and make any appropriate changes to the service. This system works well and has opened up an additional communication between patients and our staff where dissatisfaction is experienced.

Performance maps are regularly being provided from the system both at our patient experience committee every month and at other relevant forums. This mapping technique has been developed within the platform in order to fully understand the detail captured within the Your Care Matters survey. It provides our teams with clear feedback on what is most important to our patients and the specific issues that have prompted them to give lower than acceptable scoring in sections of the survey. It also clearly highlights what different areas are excelling at. This has been a great step forward in ensuring the focus for change comes directly from patient feedback and is well informed.

The launch of our new patient experience platform has provided an easy route for staff members across the organisation receiving compliments intended specifically for them. The survey pro-actively asks the patient if any staff member went above and beyond during their experience with us. This generates a senSASHional alert which is sent to designated senior staff members who are charged with providing the comments to their team members.

Friends and Family Test

The NHS Friends and Family Test (FFT) is used widely throughout the trust as a temperature gauge for patient satisfaction. It helps us understand whether patients are happy with the services we provide or where our focus for improvements needs to be directed. Our FFT results are published and discussed at Board level, clinical governance meetings and at the patient experience committee each month and are analysed with the results from our surveys to provide a rationale and detail behind the scores. Our results are also shared and uploaded with NHS England and provided with national data returns.

Overall FFT Scores 2017-18

2017	Score
April	93.65%
May	93.85%
June	92.81%
July 17	93.41%
August	93.15%
September	93.58%
October	92.75%
November	92.90%
December	92.92%
2018	Score
January	93.20%
February	93.81%
March	92.16%

Supporting carers

Our carers steering group takes place bimonthly with key staff, carers and patients in attendance. We have two carer support organisations based within the Trust who are well established to identify and provide specialist support to carers. The steering group allows us to focus and improve work in identifying and supporting carers in a consistent and effective way.

In November 2017, we hosted an event for staff who are carers to reach out to them and offer better support and educate them on their rights and access to support. This has led to a support group for our colleagues who are also carers being set-up once per month to discuss their needs and to get advice from our carer support organisations.

We have an active patient carer who comes to provide information on her experiences at staff training and she also attended one of our Trust Board meetings to tell her story.

Carer's passport

The carers' passport continues to be an established tool across the trust to provide carers of patients discounts on parking, meals in our restaurant, signposting to our carer support organisations and refreshments on ward drinks rounds. Overall it serves to identify these individuals as valued givers of patient-centred care. We have recognised that some areas of the Trust need further support to ensure the passport is provided to carers consistently and we have also identified our emergency department as an area to work with to improve carer awareness so that carers can be identified as soon as they enter the hospital.

Open visiting

Our open visiting policy is now well established across the trust. This feeds directly into work we continue to do in supporting and valuing carers.

Open visiting provides carers, family and friends with a clear invitation throughout the day to continue to support and care for their loved ones whilst they are in the hospital environment. It is felt that this scheme could have contributed to a reduction in complaints.

Although in the early stages of our open visiting project the post natal ward did not introduce open visiting, due to subsequent patient feedback, this ward has now adopted this initiative.

Wayfinding

It became evident through patient feedback that patients and visitors felt the signage throughout the hospital could be improved and that navigating the hospital was not as easy as it could be. In response to this feedback we have begun a hospital-wide project to improve signage. We now have colourful vinyl to inform the public of the zone they are entering and are in, which coordinates with our hospital site maps. The next stage will be to install further vinyl wall coverings to entrances of corridors that list services and also the provision of decision boards to enable patients to quickly decide which way they need to turn at junctions. In the coming year the outside signage will also be replaced as part of the project.

Noise at night

Due to regular feedback from patients informing us that they are disturbed by noise at night we have ensured that patients have access to ear plugs in our inpatient areas. We can also provide herbal tea and eye pads to help our patients sleep. However, we do recognise that this is still an area we could improve further and we intend to continue to strive throughout the coming months to make further improvements and this will include liaising with other organisations to share best practise and to gather ideas. We will also collect more detailed information from our patients on the type of noise specifically which disturbs them at night.

Patient stories

In 2017, we decided to open each patient experience committee with a patient story and we have found this to be an extremely powerful and meaningful way to focus on what is important to our patients. We use patient stories across the Trust at training and staff meetings and we intend to further develop this initiative by forming a group to establish if we can capture patient stories in a more impactful way. This may be by recording the patient telling their story and making a podcast or filming patients telling their stories so they can be accessed more readily by all.

Patient stories are also shared at our Trust Public Board meetings.

Compliments – saying thank you

We receive an abundance of compliments through our senSASHional feedback; from Your Care Matters; through our express feedback online forms and through letters, cards and donations to SASH Charity, given as a way of expressing thanks. The patient experience team also receive daily telephone calls from patients wishing to extend their thanks and gratitude to the trust teams.

‘The doctors are amazing and the place is very clean. Overall, it is an incredible place and has no faults in the way it runs. I will always recommend this hospital.’

‘Everything very good couldn’t find any fault - great staff.’

‘I have received exceptional care from my stay which was excellent.’

Making it better – responding to complaints

As a Trust we welcome complaints as they help us to learn and reflect on how we work and to make the appropriate improvements. We encourage our patients to discuss their concerns directly with our staff and emphasise the value of a swift and empathetic response to patient concerns.

However, if a situation cannot be resolved and patients or their carers may choose to formally complain, they can do this by contacting our complaints team or the Patient Advice and Liaison Service (PALS). Our complaints process is integral to the improvement of our services.

- ☐ In 2017-18 the Trust received 542 formal complaints
- ☐ a significant decrease of 10.2% from 2016-17

During 2017-18 the Trust received 542 formal complaints; this represents a significant decrease of 10.2% from 2016-17. The two main themes identified were in the categories of care implementation and attitude. We share key learning points with staff individually, within ward teams and at the divisional monthly governance meetings. Improvements in practice, policy and education of staff are reported and shared at the Patient Experience Committee so that good practice is shared Trust-wide.

The two main themes in 2017-18 were:

Care Implementation: problems relating to diagnosis and general nursing and medical care featured in 129 complaints in the 12 month period. This is a very broad category and is therefore the main theme within our complaints.

Attitude of staff: the last year has seen a steady reduction in the number of complaints related to the attitude of staff.

The complaints team continue to provide a personal and responsive service to complainants. The Trust expects to acknowledge all complaints within three working days. In 2017-18 the complaints team achieved this target in 100% of cases. We have significantly improved response rates achieving an average of more than 86% of all complainants receiving a response within agreed timescales. This is an increase from 58% the previous year.

The complaints team actively solicit feedback on the complaints process from patients or carers who have had cause to use it. Positive feedback has included:

‘The response was very quick. The complaint was taken seriously and I was spoken to in understandable terms - not jargon.’

‘I was kept up to date and the feedback showed progress which will hopefully ensure a similar experience is avoided for others.’

Nationally, referrals and investigations undertaken by the Parliamentary Health Service Ombudsman (PHSO) have increased. During 2017-18, 14 of our complaints were referred to the PHSO. Of these none were fully upheld, three were partially upheld and one was not upheld; four cases were not taken on for investigation and a further six cases are still awaiting an outcome.

The complaints team value the expertise and support of ward-based staff, clinicians and managers, in the timely and appropriate resolution of complaints. Working together the Trust aims to restore the confidence of patients or carers, who have had cause to complain, in our services and ensure that the learning raises standards.

Digital conversations

We continue to see a steady increase in visitors and traffic to our website and social media sites. Our website provides our patients, relatives and visitors with useful resources about their care or visit to SASH, including tools to provide feedback about the care they received.

Our social media platforms allow us to connect with patients, relatives and our community by sharing SASH updates and information as well as collecting and responding to feedback shared with us on social media.

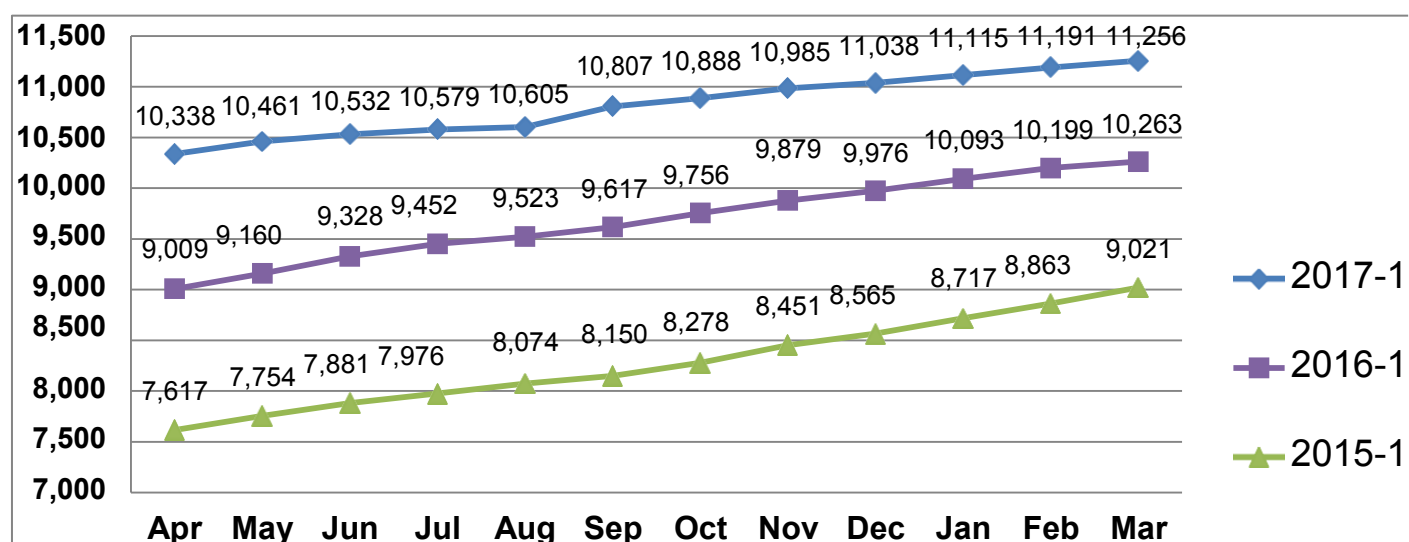
The numbers of people engaging with SASH through our social media sites continues to grow:

Twitter



Gained 993 new followers in the last year

- ✓ 11,256 in March 2018
- ✓ 10,263 in March 2017

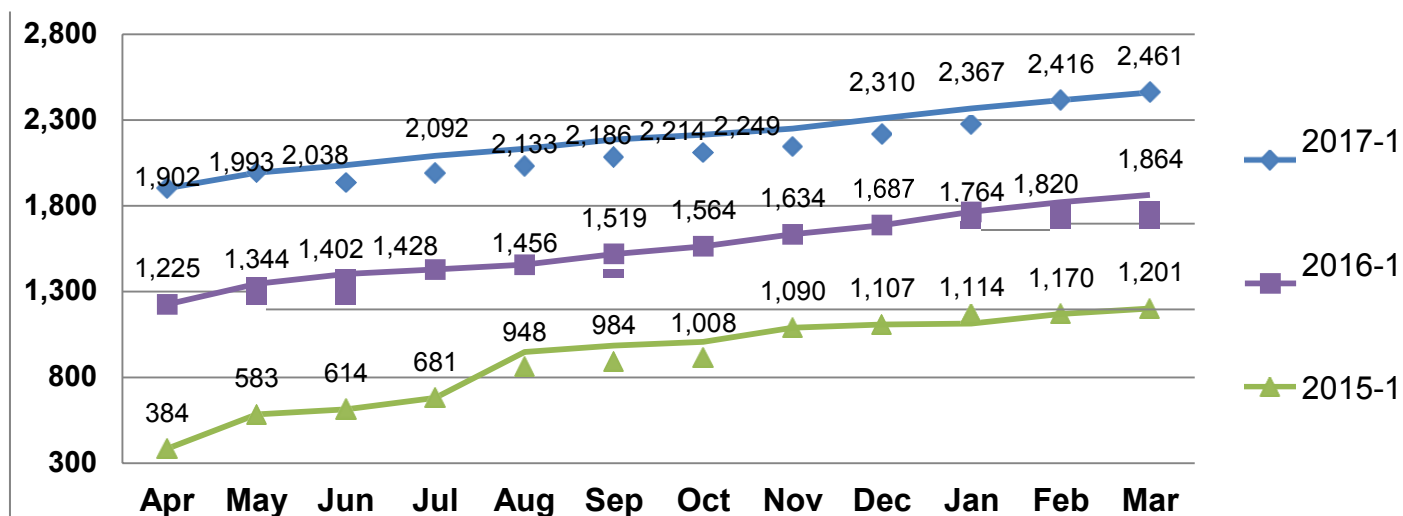


Facebook



Gained 597 new likes in the last year

- ✓ 2,461 in March 2018
- ✓ 1,864 in March 2017

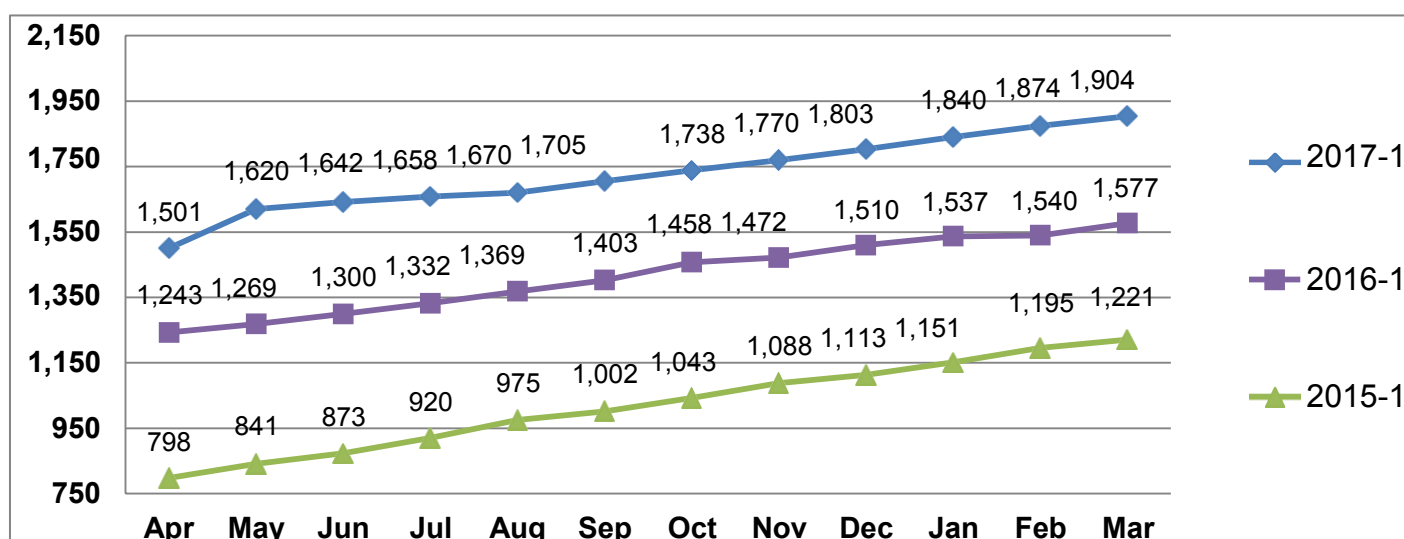


LinkedIn



Gained 327 new followers in the last year

- 1,904 in March 2018
- 1,577 in March 2017

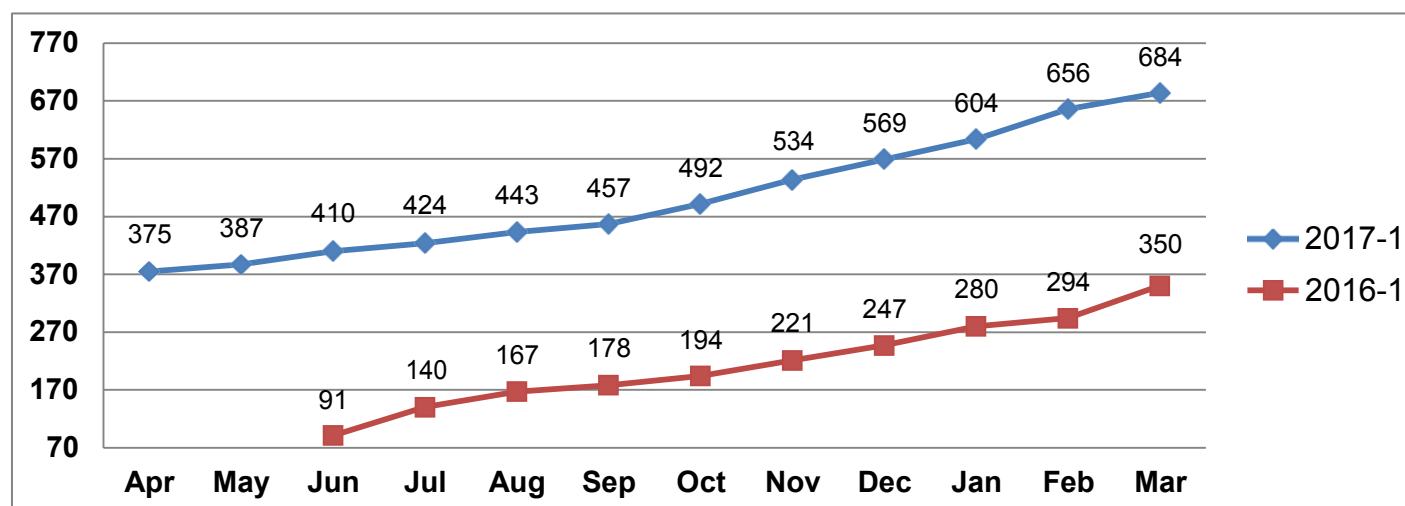


Instagram



Gained 334 new followers in the last year

- 684 in March 2018
- 350 in March 2017



You Tube



Gained 61 new subscribers in the last year

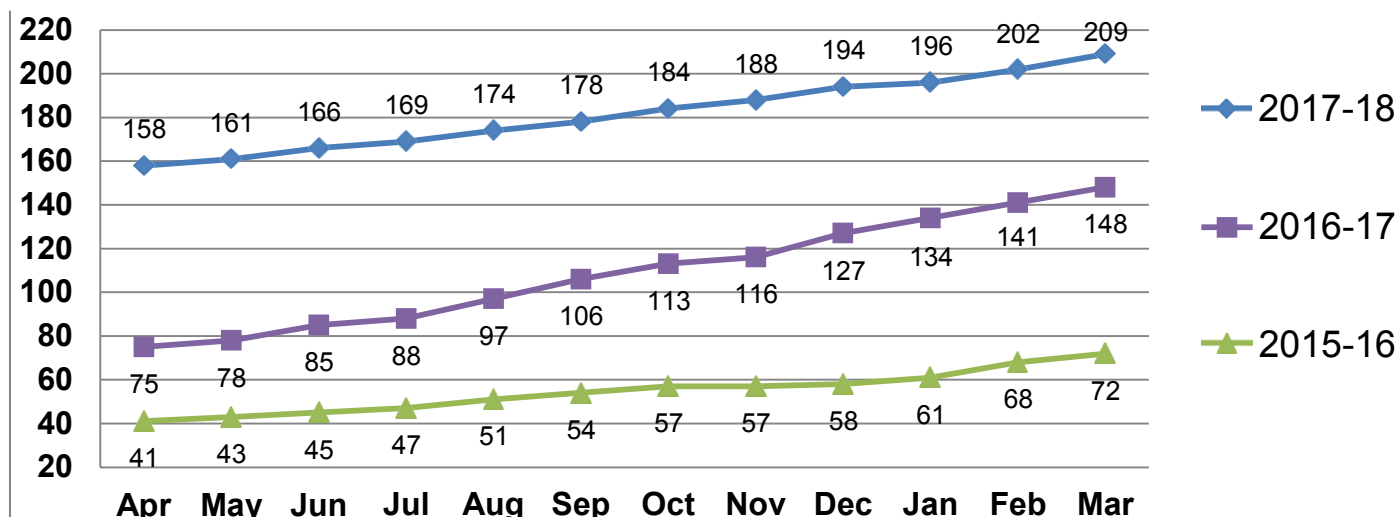
- 209 in March 2018
- 148 in March 2017

27,440 views in the last year

- 71,965 minutes

Most watched video: [Your Operation at East Surrey Hospital](#)

□ 10,102 views



Website

- 1,212,374 page views
- 290,035 unique visitors to the site
- 456,512 sessions

3,337 sessions came via social media (1.1% of sessions)

- Facebook: 2,200 sessions (65.65%)
- Twitter: 873 sessions (26.05%)
- LinkedIn: 244 sessions (7.28%)
- YouTube: 7 sessions (0.21%)
- Instagram: 4 sessions (0.12%)
- Other: 23 sessions (0.69%)
 - Pinterest, Blogger, reddit, Pocket

Our people

We have a workforce of over 4,200 people in a broad range of clinically registered professions and support roles and value everyone for the part they play in delivering high quality care to our patients through our one team approach.

Who we are

Staff Group	Headcount	% of Workforce	% Female	% Male
Nursing and midwifery registered	1,185	28.11	92	8
Administrative and clerical	814	19.31	83	17
Support to clinical services	795	18.86	78	22
Medical and dental	645	15.30	52	48
Estates and ancillary	361	8.56	49	51
Allied health professionals	209	4.96	85	15
Additional prof scientific and technical	120	2.85	78	22
Healthcare scientists	84	1.99	67	33
Students	2	0.05	100	0
Grand Total	4,215			

National NHS Staff Survey

We received a fantastic response to the 2017 National NHS Staff Survey – over 67% of staff completed the survey and our results were equally impressive. We recorded 25 of the 32 Key Findings in the Top 20 percent nationally and five of these were the highest scored for acute Trusts. We continue to score in the Top 20 percent nationally for staff engagement and for staff recommending SASH as a place to work and receive treatment. We continue to use the feedback from the survey to deliver improvements for staff.

Key findings:

Of the 32 key findings from the survey, we recorded:

- ☐ 25 in the top 20 percent
- ☐ four were average
- ☐ one was below average
- ☐ two in the lowest 20 percent

Where we are in the top 20 percent of Trusts

- ☐ Staff recommendation of the organisation as a place to work or receive treatment
- ☐ Staff satisfaction with the quality of work and patient care they are able to deliver
- ☐ Percentage agreeing that their role makes a difference to patients and service users
- ☐ Staff motivation at work
- ☐ Recognition and value of staff by managers and the organisation

- ☐ Percentage of staff reporting good communication between senior management and staff
- ☐ Percentage able to contribute towards improvements at work
- ☐ Staff satisfaction with level of responsibility and involvement
- ☐ Effective team working
- ☐ Support from immediate managers
- ☐ Quality of appraisals
- ☒ Quality of non-mandatory training, learning or development
- ☐ Staff satisfaction with resourcing and support
- ☐ Percentage of staff satisfied with the opportunities for flexible working patterns
- ☐ Percentage of staff feeling unwell due to work related stress in last 12 months
- ☐ Percentage of staff feeling pressure to attend work when feeling unwell
- ☐ Organisation and management interest in and action on health and wellbeing
- ☐ Percentage believing the organisation provides equal opportunities for career progression / promotion
- ☐ Low numbers of staff saying they have experienced harassment, bullying or abuse from staff in last 12 months
- ☐ Percentage of staff reporting their most recent experience of harassment, bullying or abuse from staff
- ☐ Percentage witnessing potentially harmful errors, near misses or incidents
- ☐ Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- ☐ Confidence to report experience of harassment, bullying or abuse
- ☐ Staff confidence and security in reporting unsafe clinical practice
- ☐ Staff feeling there is the effective use of patient and service user feedback

Whilst this provides a positive overview, there were two key findings where the Trust was in the lowest 20% nationally. These were:

- ☐ Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- ☐ Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

We are aware that due to the wide variety of conditions SASH patients attend with, there will be a range of different types of incidents that have occurred related to bullying, harassment or violence from patients to staff. Incidents may occur due directly to a patient's condition, for example, patients with dementia, or related to other factors such as being under the influence of drugs or alcohol.

We will review staff experience with patients to understand in much more detail the incidents that have occurred to ensure that relevant interventions can be developed and implemented to address these. Detailed action plans are being put in place to support our staff and to address the concerns and issues raised and these will build on many existing awareness campaigns; training and support for staff across SASH.

The data is used by the Survey Coordination Centre (Picker Institute) in the NHS Benchmark Report, which presents the data under the four staff pledges and three additional themes of equality and diversity, errors and incidents and patient experience measures.

Whilst our overall scores in the 2017 National Staff Survey have not improved in relation to this key finding, initial feedback from staff has been positive and in a recent survey over half of our staff felt the campaign has had an impact and reduced inappropriate behaviours from patients and visitors towards staff in their work area. We will continue to develop the scheme.

It's not okay

Following the responses of the 2016 National Staff Survey, staff had identified bullying and harassment from patients and the public as a key issue. On investigation, the Trust found that many instances of bullying and harassment were not recorded by staff via the formal Trust reporting processes as staff did not see actions being taken when they took the time to report these.

As a result, we introduced the 'It's Not Okay' campaign highlighting the behaviours our staff expected from patients and the public. Along with this, where incidents are reported by staff, a member of the Trust executive team will meet with the individual member of staff to discuss the incident in more detail and provide relevant support to them and their wider team.

'I am delighted to know how positive staff feel about working at SASH and the strong link with this and the quality of care they are able to provide.'

Not only is this important for everyone at SASH it is, of course, especially important for our patients and the people we care for.'

Michael Wilson CBE

Chief executive

Freedom to Speak Up and Safer Working Guardians

The Francis Inquiry report and subsequent reports including the Freedom to Speak Up review highlighted the need for organisational culture change across the NHS.

In light of the recommendations, SASH has an independent Freedom to Speak up

Guardian and Safer Working Guardian. The role of the Freedom to Speak up Guardian is to encourage and support staff to raise concerns and ensure that the voice of our people is heard clearly at a senior level within the organisation. They have a clear remit from the chief executive and the Trust Board to act freely, with complete autonomy from the management team, as an alternative route for issues of concern to be raised at the highest level. The Trust also has an established Safer Working Guardian who oversees the wellbeing of our junior doctors.



SASH Star Awards – recognising achievement

The SASH Star Awards have become a key date in the SASH calendar and every year they become bigger and better. The Awards are a real celebration of our staff and the amazing contribution they make on a daily basis. The quality and diversity of the nominations is a real testament to our staff.

We increased the number of awards this year so we could showcase and recognise more of the excellent work SASH staff continuously delivers. Awards were presented for:

- Improving patient experience
- Supporting diversity in the workplace
- Innovation and service improvement
- SASH values
- Frontline employee of the year
- Behind the scenes employee of the year
- One team - frontline team of the year
- One team - behind the scenes team of the year
- Apprentice of the year
- Volunteer of the year

Developing our staff

We have been developing the SASH education and development strategy, which was approved by the Trust Board in January 2018. The strategy describes the vision for educating and developing staff and the healthcare workforce of the future. The strategy encompasses three key principles:

- ✓ **Developing our talent** - at all levels from entry level to senior roles maximising opportunities for career enhancement
- ✓ **Inclusive learning culture** – enhancing the ‘one team’ value through building

- capacity for learning and development through a blend of learning methods and maximising opportunities for multi-professional and work-based learning
- ✓ **Continuous improvement and transformation** – ensuring education and development delivery models are dynamic and take account of changing and future service needs and learner feedback

Five education objectives provide the framework for the underpinning operational delivery plan aligned with SASH's strategic objectives. Key work streams include:

- ✓ strengthening the education governance structure
- ✓ increasing engagement for apprenticeship development programmes
- ✓ embracing new roles, for example, nursing associate and advanced clinical practitioner
- ✓ leadership development
- ✓ developing internal educators and mentor capacity

The education governance group has been refreshed playing a key role in the development of the strategy and operational plan.

The Trust has a multi-professional bursary panel that supports the development of staff through the provision of funded external learning opportunities. The bursary panel makes funding decisions and ensures the resources for training and development of staff are utilised effectively. In 2017-18 the bursary panel approved applications from a wide range of members of staff from different departments and disciplines - supporting their ongoing professional and personal development.

The annual achievement review (appraisal) process provides staff with valuable feedback and recognition for their performance over the year and is an opportunity to discuss and agree a personal development plan. In 2017, over 90% of staff were reported as having completed an appraisal and the Trust is ranked in the top 20% nationally for the quality of appraisals.

The internal programme of personal effectiveness skills workshops has been refreshed during the year. The suite of workshops available to staff focuses around communication and well-being, including developmental mentoring which supports anyone providing supervision, assertiveness, conflict resolution and customer care.

South London and Maudsley NHS Foundation Trust were commissioned to deliver a number of workshops in the autumn focusing on stress and mental health awareness as part of the Trust's programme of health and wellbeing. Following their success, additional workshops have been developed and added to the programme to enable staff to explore practical approaches to wellbeing and concepts of resilience and mindfulness.

In addition, another successful Essentials of Management programme was delivered in year where new leaders cover a range of management topics with input from various Trust experts. The Trust is ranked in the top 20% nationally for quality of

non-mandatory training, learning and development.

In the latter part of the year SASH was successful in gaining funding to develop a SASH leadership framework as part of the approach to talent management and developing SASH leaders. The first phase of the project concluded in February 2018. This phase focused on engagement gaining input from the executive team, managers and staff as part of the design of the leadership framework building on the Trust values and behaviours. We are expecting the framework to be available to staff in 2018-19

There is a programme of continuous review to ensure efficient and effective delivery of induction and mandatory training. During the year the workforce committee endorsed changes to the mandatory training matrix, these included clarification of refresher periods for some topics and the development of one simplified document that will be launched in April 2018. Preparation work has also been progressed to introduce e-learning for 2018-19. where appropriate, in place of face-to-face training or to help with increasing capacity and compliance. The corporate element on the induction course for new staff has been further strengthened to enhance the overall welcome and key messages to staff about what's expected of them and how we support and develop staff at SASH. New topics have been introduced, including an introduction from the speak-up guardian and major incident training. Close working with service areas continues to ensure strategies are put in place to address any non-compliance hot spots in particular to help improve compliance.

SASH hosts a range of students on placements as part of their formal undergraduate training with the majority in nursing and midwifery. Students who have good placement experiences and live locally often take up roles at the hospital others choose to work on the temporary staffing bank during their training.

The annual education audit process was successfully concluded in January 2018 and the University Surrey approved SASH student nursing; midwifery; operating theatre practitioners; paramedics and foundation degree placements for a further year. The educational audit is accepted by other partner universities such as the University of Brighton, University of Portsmouth and the Open University.

Our practice development team provides education and training for nursing and support staff, covering clinical skills, preceptorship, revalidation, overseas recruitment, career development and the national Care Certificate programme.

Our library and knowledge services have provided the best available evidence to inform and support the delivery of safe, high quality care not only to staff and students within the Trust but also to those working across the whole of the local health economy including paramedics; primary care; mental health and community organisations. We have provided access to literature, evidence and research and summarised evidence and carried out horizon scans to support clinical and non-clinical staff. More widely, we have undertaken specific work to support the

implementation of sustainability and transformation plans, opportunities for digital medicine in the future and to inform workforce strategy development at a national level.

For the fourth successive year the team has achieved 100% across all 48 criteria for the NHS Library and Knowledge Services Quality Assurance Framework.

Off-payroll engagements

Sometimes, it is necessary for the Trust to make use of the skills of external contractors rather than employed staff. At these times, we ensure that the arrangements comply with our standing financial instructions and offer good value for money. We also ensure that our contracts require contractors to comply with the relevant tax and national insurance requirements.

In 2017-18, no members of staff were on off-payroll engagements for more than £245 per day and more than six months, (11 in 2016-17).

Staff engagement

Staff engagement is key to SASH being able to deliver high class quality and safe care to our patients. It is known that engaged and motivated staff improve patient outcomes.

We have a well-established network of different forums and mediums to engage with staff including:

- ✓ TeamTalk briefings hosted by the chief executive
- ✓ Chief executive's weekly message
- ✓ annual NHS Staff Survey: The response rate for the Trust was 67% in 2017, which is in the highest 20 percent nationally
- ✓ Quarterly Staff Friends and Family Test
- ✓ Regular meetings with trade union colleagues
- ✓ SASH+ improvement work.
- ✓ Divisionally-led briefings and team meetings
- ✓ Freedom To Speak Up Guardian and Guardian of Safe Working roles now embedded within SASH

We continue to score in the Top 20 percent nationally for staff engagement in the National NHS Staff Survey. Our established staff engagement strategy supports ongoing work to ensure that all our staff maintain a strong connection with the vision and values of the organisation.

Equality, diversity and human rights

During 2017-18 we have been developing the SASH One Team Inclusion Strategy. in conjunction with brap (an equalities charity); the Trust Board; executive team;

union colleagues and other key stakeholders, including members of our Black, Asian, minority ethnic (BAME) network.

We have a duty to ensure we provide equal access and opportunity to all of our people, whether they are our staff, patients or the public and regardless of whether they have a protected characteristic such as gender, race or age. Our inclusion strategy, and action plan, will support the delivery of this. We have also met our Public Sector Equalities Duties.



Surrey Choices

We continue to work in partnership with Surrey County Council through the Surrey Choices employability scheme to provide work placements for young adults with learning disabilities. The majority of the placements have been with the SASH catering and library teams.



Black, Asian, minority ethnic network (BAME)

The role of the Black, Asian, minority ethnic (BAME) network is to be an independent voice for staff from a black, Asian and minority ethnic backgrounds. It is also to ensure the NHS delivers on the NHS England workforce race equality standard and to support SASH to meet its statutory duty to promote racial equality, eliminate discrimination and promote inclusion.

The BAME is an inclusive staff network, also open to non BAME members who are interested in race equality and inclusion. The SASH BAME staff network was launched in 2017-2018 and now has over 50 active members.

The objectives of the BAME network are to:

- ☐ Improve the representation of BAME staff within the Trust especially at senior level
- ☐ Ensure that all minority groups have a voice and feel supported and valued
- ☐ Assist and influence policy and decision making reflective of equality, diversity and inclusion
- ☐ To provide opportunities for diverse individuals to come together, support each other and share ideas
- ☐ To continue to improve outcomes and experience for BAME patients treated within the organisation

As well as creating better opportunities for BAME staff within the Trust, the network gives members of the network access to a forum for support, support policy development and build relationships with different groups within the organisation.

‘The BAME vision is to be an independent and effective voice for BAME staff, patients, service users and carers to ensure SASH delivers on its statutory duties regarding race equality.’

Gillian Francis- Musanu

Director of corporate affairs

Chair of the BAME network steering group

Occupational health, safety and wellbeing

Following the opening of the new purpose-built Occupational Health Unit at East Surrey Hospital, we have been able to take a more proactive approach to staff health, well-being and safety. We are keen that staff take care of their wellbeing and we promote regular wellbeing activities through our SASH Active campaign.

The Unit provides clinics and consultations, as well as hosting complementary therapists sessions for staff. Our health and safety team are also based in the unit, building on our collaborative working and enhancing our ability to provide a safe and supportive environment for all our staff.



SASH Active

As part of our commitment to staff wellbeing we have continued to develop our SASH Active programme, which provides opportunities for staff to engage in a wide range of activities to support both physical and mental well-being. We offer staff the opportunity to:

- ☐ Sing in the SASH NHS Community Choir
- ☐ Take part in circuit training
- ☐ Have a massage and other complementary therapies at reduced rates
- ☐ Walk with colleagues at lunchtime
- ☐ Read with our book club
- Receive a flu vaccination (in 2017-18 we achieved a 72% take up of frontline staff which is the Trust's highest year recorded)
- Feedback through the It's Not Okay campaign

Our staff have recognised the commitment we have made to them in terms of their wellbeing and have rated SASH in the top 20 percent nationally in the National NHS Staff Survey 2017 for organisation and management interest in and action on health and wellbeing.

Our volunteers

SASH has a strong history of valuing the rich contribution that volunteers make to patients and staff at the hospital and we are privileged to have many long serving members who continue to dedicate their time to benefit the local community.

This year has been a period of change as the Trust has continued their work with partner organisations and diversified the way that volunteers are deployed, creating new roles including the launch of Dementia Friends and providing opportunities for underrepresented groups to engage with volunteering. A new charter and policy has been developed in collaboration with volunteers to further consolidate the organisations commitment to this important work.

Our volunteers contribute in many ways including:

- ✓ Supporting the patient advice and liaison (PALS) team
- ✓ The development and ongoing upkeep of our courtyard garden areas.
- ✓ Maintenance of our various fish tanks across East Surrey Hospital
- ✓ Pets as Therapy dogs who visit our patients
- ✓ Staffing our information desks

- ✓ As Dementia Friends
- ✓ Acting as ward assistants and administrative support in clinical areas
- ✓ Providing a patient trolley service

The onsite East Surrey Macmillan Cancer Support Centre is staffed by a substantive centre manager and volunteers who provide invaluable support and advice to those affected by cancer. Volunteers offer a range of complementary therapies and emotional support and are a lifeline for many patients in the area.

Radio Redhill, has 70 volunteers who visit the hospital wards talking to patients, collecting their music requests and then playing them on the daily request programmes, which can be heard on ward headsets, on personal radios and online. Highlights over the past year include: being a finalist in the Station of the Year category and a winner in the Special Event category of the National Hospital Radio Awards for their coverage of the visit of the Flying Scotsman to the Bluebell Railway. Maria Speller, a Radio Redhill member, received a Volunteers Award from the Mayor of Reigate and Banstead for her 30 years of service to hospital radio.

‘Thank you to all our volunteers who, every year, give thousands of hours of their time to support our teams and provide a warm welcome to our patients and visitors.’

Alan McCarthy
Chair

Work experience students

We continue to strengthen our links with our local community, schools and colleges through our involvement with a range of careers events and work experience placements.

This year, the Trust received over 160 applications for the scheme and we successfully hosted 125 work experience placements between April and November 2017. A total of 88% of work experience placements were offered to those between 16 and 18 years of age to help inform career choice.

A number of work experience students from previous years are now at university studying their chosen career; others join the staff bank and work with us part-time whilst completing their studies thereby providing the opportunity to broaden their breadth of experience and develop their skills.

Supported by our colleagues from clinical and non-clinical areas we also attended seven career events to promote careers within the NHS and promote SASH as an employer of choice, these included Women in Science Career (WISE) and Science, Technology, Engineering and Maths (STEM) events to align with the national agenda of promoting study of and careers in these subject areas.

In late March 2017 we were delighted to offer a prize day to the winners of the Surrey region NHS Schools competition and offered many interactive experiences for them including visits to the simulation suites and a chance to get hands on with the mannequins and the opportunity to learn how to restart a heart with our specialist resuscitation team.

In March 2018 we hosted our first meet the practitioner event at East Surrey Hospital providing students from local colleges the opportunity to meet with healthcare professionals and gain and insight into their roles.

Apprentices

Apprenticeships align with the widening access agenda to aid the recruitment of staff from our local community and provide our substantive staff the opportunity to undertake vocational learning to enhance their career development.

The landscape of apprenticeships is changing and this year saw the introduction of the apprenticeship levy which requires employers with an annual wage bill of over £3m to contribute 0.5% into a levy account which is then ring fenced to spend on apprenticeship training.

The introduction of the levy has provided opportunity for new schemes such as the nursing associate Apprenticeship programme that we are running in conjunction with the University of Brighton. Eleven SASH trainee nursing assistants have been successfully selected on to this programme as part of a cohort of over thirty trainees together with six NHS partners across the region. Once qualified, nursing associates will deliver care with a wider skill set enhancing their overall scope of practice, and complementing the work of registered nurses. This will ultimately enhance the way patient care is provided and increase capacity within the healthcare professions.

The apprenticeship levy provides a great opportunity for the Trust to offer a wide range of apprenticeship development programme for existing staff. In addition to the trainee nursing associates, SASH currently has staff enrolled on programmes in the following subject areas:

- business administration
- team leading
- health and social care
- pharmacy services
- food production and cleaning

During National Apprenticeship Week we were delighted to celebrate the achievements of 16 colleagues who successfully achieved their apprenticeship qualification in subjects ranging from cleaning and hospitality to business administration, team leading and management.

Other healthcare specific apprenticeship development programmes we are hoping to introduce in the coming year include:

- ✓ Healthcare support worker levels 2 and 3
- ✓ Healthcare science levels 2,4 and 6
- ✓ Assistant practitioner level 5
- ✓ Advanced clinical practitioner level 7

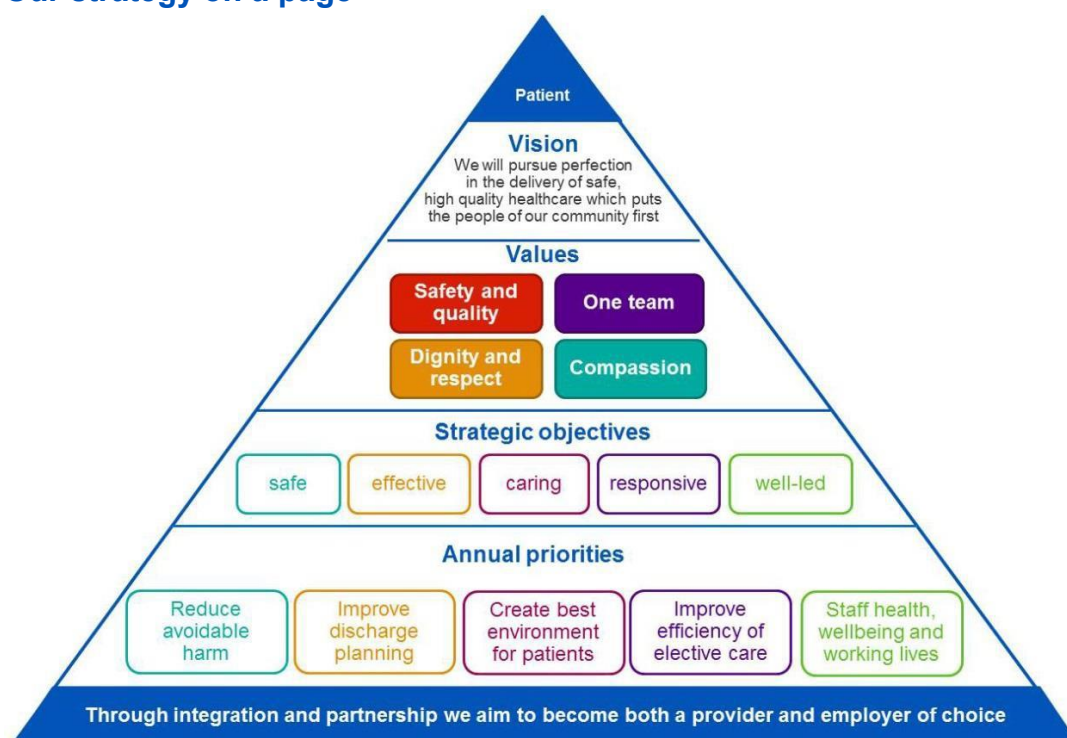
The Trust also plans to introduce management apprenticeship development programmes from level 3 upwards.

Our plans

Our strategy

Our strategy was refreshed for 2017-18 and the strategy on a page taken by frontline services and translated into localised plans. During the year we moved to a position where all wards had a set of plans to deliver against the strategic objectives and annual priorities whilst also taking account of their local patients needs. This has been an excellent way to ensure our staff understand our vision and strategy as an organisation and how they play an integral role in the delivery of it.

Our strategy on a page



During the year we introduced *Let's Talk* sessions with staff. The focus of these sessions was to gain feedback on the strategy in terms of how well it was understood, the strategic objectives and the values in terms of how well embedded they are and if they were still relevant. The review of the strategic objectives supported conversations to identify where gaps still exist and where good practice was being taken forward. An overview of feedback from these sessions is provided below:

Areas we do well	Areas where we could do better
Team Work	Staffing levels can be challenging
Embedding Values	Staff Health and Well Being – access to fitness, gyms, showers, hypnosis, mindfulness etc
Communication	Communication across all divisions from the Genba (the “shopfloor”) to the Board
Quality of care	More time for multi-disciplinary training and access to organisational development
Passion for the job	Right Patient Right Bed – this was considered to be a key issue for patients but also for staff who are sometimes unable to use the specialist skills they have developed
Patient Safety	Encouraging our staff to have conversations about dying as early as possible to support the development and delivery of the best end of life care possible
Service User Engagement	Some staff environments do not support the ability to take a break or work pressures do not mean that staff take their breaks when they need to
Hospital environment is clean	Communication systems could reduce wasted time trying to contact members of

	the team involved in a patients care eg pagers, apps that could be on staff mobile phones, issues around speed of wifi
It is good that the Trust is engaging with staff like this	Form filling – maximise the use of IT to reduce paperwork

Many of the issues raised were resolved as and when the issues were noted and others have become part of longer term pieces of work that fit with the wider strategy for example:

- ✓ the staff health and well being programme of work incorporates a number of schemes to provide fitness classes to staff
- ✓ the wifi throughout the hospital has been upgraded
- ✓ funding has been agreed for the implementation of electronic patient record

During the year our nursing teams have undertaken work with services to further embed values. Additionally, we also practise values based recruitment.

Staff feedback was that the values were known, understood and provided a platform to encourage the right behaviours in the workplace. It was agreed that the values should remain as they are and they would continue to be embedded in the organisation.

Our strategic objectives

The strategic objectives have been refreshed for 2018-19. They have been ammended to reflect the changing environment; the need to move towards integrated healthcare systems; the need to work with our patients to design their healthcare and the need to use innovative IT to plug the gaps that we see in staffing resource as well as helping patients to own their care. The revised strategic objectives are:



Our annual priorities

For 2018-19 we have agreed that many of the annual priorities are still relevant and need to continue to be areas of focus. The one priority that will change is that of improving efficiency in elective care; this change is partly due to improvements that have been seen in 2017-18 in both areas of theatres and outpatient efficiency but also to reflect the need to focus on responsiveness across all services. Our new priority for 2017-18 is timely access to services.

The 2018-19 refreshed priorities will be subject to the same process that was delivered for 2017-18 with all teams taking the strategy on a page and translating it into their local plans. This process is also supported by divisional and corporate business plans that layout the programmes of work for the year.

The key developments delivered through the annual plan in 2017-18 are:

- ✓ Day Surgery Unit
- ✓ Kingsfold Unit – our new ambulatory care facility
- ✓ New Emergency Department GP triage area
- ✓ More research participants in 2017-18 than ever before
- ✓ 100 SASH+ Lean for Leaders trained
- ✓ Increased productivity in outpatients and theatres by reducing cancellations and 'did not attends' and maximising theatre time
- ✓ Development of a health and well-being plan
- ✓ A new inclusion strategy

- ✓ Launch of the dementia strategy and Dementia Friends; roll out of the Butterfly Scheme and the development of a new courtyard garden specifically aimed at patients suffering from dementia
- ✓ A newly launched patient and public engagement strategy
- ✓ A new approach to volunteering was developed which has resulted in increasing the number of volunteers and the range of skills and experience brought into the organisation
- ✓ STP population analysis that lead to agreeing a plan to focus on 11 pathways which will now form part of the system wide recovery programme to address the financial deficits seen in organisations that work with and around us.
- ✓ A new approach to charitable funds to maximise opportunities to improve our services for patients and staff
- ✓ New academic appointments with the University of Surrey to support our ambition to become a well-respected training and education provider
- ✓ Launch of co-design methodologies in the area of chronic obstructive pulmonary disease (COPD) with excellent feedback from local clinicians and patients

STP – working in partnership

SASH has continued to play an active role in the development of the Sussex and East Surrey Sustainability and Transformation Partnership (STP). The STP is a new way of working. It brings together the 24 health and care organisations (clinical commissioning groups, NHS Trusts and local authorities) in the area to work together to address the significant challenges faced by local health and care services.

Collectively, we want to do more to prevent illness, to support people to manage existing health conditions and to stay independent. We also recognise that we need to work differently if we are to continue meeting the rising demands of a growing and aging population from within the limited resources available.

The STP aims to ensure that no part of the system works in isolation, working together to improve health, wellbeing and services and to make the best use of the available resources.

During 2017-18 the STP has:

- ✓ Established models for providing more integrated community-based care. These place-based plans will help people stay well closer to home, reducing demand on GPs and hospitals
- ✓ Engaged partners across health and social care and the voluntary sector including clinicians and service users in developing plans for a radical overhaul of mental health services that could deliver significantly improved

- outcomes for people with mental ill health along with significant annual savings for the wider health and care system
- ✓ Supported clinicians to address unwarranted clinical variation in order to improve outcomes and reduce waste
- ✓ Facilitated closer joint working between commissioners, enabling them to pool resources and expertise and simplifying arrangements for provider Trusts
- ✓ Begun work to establish a unified approach to data sharing across partners, enabling services to be targeted at those who need them most and unblocking barriers to safer, more integrated care
- ✓ Developed joint approaches to winter preparedness, strengthening local plans by working together

Performance

Working together, our teams are focused on delivering high quality services to the people we care for. Many of the key areas for delivery are measured by national standards and we have listed these together with our performance below.

Activity – the numbers

This year continued to be a challenging one for both emergency and elective care services across the Trust with unprecedented numbers of people attending our emergency department (ED) or being admitted as an emergency.

In 2018-19 we also saw increases in the number of patients choosing SASH as their secondary care provider of choice within the catchment population for elective care services (outpatients and elective operations). This growth continued to put pressure on the capacity of the Trust across beds, clinics and diagnostics.

	2016-17	2017-18	Change	%Change
Emergency attendances	96,148	99,071	2,923	3.0%
Outpatient appointments	363,988	374,006	10,018	2.8%
Emergency Admissions	34,194	36,334	2,140	6.3%
Births	4,546	4,516	-30	-0.7%
Elective admissions	46,642	48,659	2,017	4.3%

Table: Activity numbers

	Standard	2016-17	2017-18
ED 4hr standard	95%	94%	92.3%
ED 12 hr breaches	0	0	0
Cancer two week rule (TWR)	93%	94%	93.2%
Cancer 62 day	85%	87%	TBC
Referral to treatment (RTT)	92%	91.7%	TBC
Diagnostics over six weeks	1%	4.1%	TBC

Table: Performance against key national standards

The table shows the Trust's performance against key national standards which reflects the pressures from the increased activity as well as a number of other factors described in the following sections.

	Q1 Apr-17 May-17 Jun-17			Q2 Jul-17 Aug-17 Sep-17			Q3 Oct-17 Nov-17 Dec-17			Q4 Jan-18 Feb-18 Mar-18		
ED 95% in 4 hours - LAEDB performance	94.8%	93.4%	94.8%	95.9%	96.4%	96.4%	95.9%	96.8%	95.1%	92.8%	92.7%	94.6%
ED 95% in 4 hours - Trust performance	92.9%	92.6%	92.8%	93.6%	94.4%	94.1%	93.2%	95.0%	92.3%	88.2%	87.6%	90.7%
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	0	0	0	0	0	0	0	0
Cancer - TWR	93.0%			91.2%			94.5%			94.2%		
Cancer - 62 day Referral to Treatment Standard	86.2%			87.0%			87.3%			85.5%		
RTT Incomplete Pathways - % waiting less than 18 weeks	88.7%	87.3%	87.3%	86.9%	86.4%	86.1%	86.6%	87.9%	87.9%	88.8%	88.6%	89.4%
RTT Patients over 52 weeks on incomplete pathways	19	53	51	33	23	20	22	19	17	17	14	19
Percentage of patients waiting 6 weeks or more for diagnostic	0.4%	0.7%	1.0%	0.9%	0.7%	0.8%	1.19%	0.7%	0.3%	0.7%	1.10%	0.6%
No of operations cancelled on the day not treated within 28 days	7	18	21	15	5	11	19	8	15	22	13	22

Table: Access to services

Emergency department: four hour standard

The emergency department four-hour standard (patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours) has been a significant challenge across the country throughout 2017-18. The delivery of the standard continues to be a key priority for the Trust. Despite not meeting the target during 2017-18, our performance significantly exceeded the national average and was consistently in the upper decile for performance of Type 1 departments over the winter period. The Trust has invested in two new services during 2017-18 to help manage both emergency demand and patient experience.

In November 2017 the Trust opened the Kingsfold Unit, a dedicated facility providing care for patients who are mobile and medically stable that benefit from rapid assessment, relevant investigation and treatment. The service has improved both patient experience and safety by ensuring that patients receive the right care in the right place at the right time. The service supports admission avoidance, with suitable patients avoiding prolonged waits in the Emergency Department, having their assessment and then being discharged with treatment and a care plan in place for follow up support.

In addition, the Trust invested in the redesign of the emergency department front entrance and implemented a pathway of GP streaming in partnership with NHS Improvement and our commissioners - creating a GP led service within the ED ensuring patients receive the most appropriate level of care for their health need.

The impact of these changes is expected to be seen throughout 2018 as we continue to work with the local health system to ensure that plans are put in place to support delivery of the ED four hour standard.

The Trust has also continued to work as part of the Local Accident and Emergency Delivery Board (LAEDB) to deliver the best access to emergency services for our local population. This is the forum where all partners across the health and social care system work together to undertake the assurance of service delivery and performance for emergency care. The positive output of this work is seen with our LAEDB performance against the four hour target significantly exceeding the national average and placing performance in the top decile of non-specialist hospitals over the winter months

Cancer waiting times

Cancer access targets have remained a significant focus for the Trust this year. The number of patients treated as part of the 62-day standard, a maximum two month 62-day wait from urgent referral for suspected cancer to first treatment for all cancers, increased by five percent in 2017-18. As in the previous year, the overall performance was above the operational standard for all four quarters in 2017-18.

The total number of patients seen as part of the two week wait standard, patients seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected, increased by three percent in 2017-18. The Trust successfully achieved the two week rule (TWR) standard in Quarters 1, 3 and 4 with lower than expected performance during Q2 due to internal capacity, referral volumes and the impact of patient availability over the summer months.

We continue to work to improve pathways to support the implementation of the national cancer strategy. This, together with our work as part of the Surrey and

Sussex Cancer Alliance five high-priority pathway groups will continue to focus on improving outcomes for our patients.

Referral to treatment/diagnostics standard

The 18 week referral to treatment/diagnostics standard (where patients start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions) has been challenging throughout the year with the impact of emergency pressures, on-going recruitment challenges and capacity shortfalls in key specialities. As a result, the Trust has not achieved the incomplete target since November 2016.

The Trust has invested in validation and pathway tracking resource, improving the quality of the data and the visibility of patient treatment plans. This, together with the prioritisation of urgent cases, means we have also treated and stopped a high number of pathways for patients who had waited under 18 weeks for treatment, which has impacted overall performance.

Performance is expected to return to 92 percent during Q3 of 2018-19 once sustainable solutions to current challenges have taken effect.

We have continued to develop our elective services this year with the opening of the Surgery Centre in June 2017. The new state of the art centre has two procedure rooms, three consultation rooms and recovery, trolley and waiting areas. The new facility has helped us streamline our day surgery service and supported the significant reduction in the number of patients who have their surgery cancelled due to bed pressures by 28 percent.

The six week diagnostic standard (where patients waiting for a diagnostic test should have been waiting less than six weeks from referral) was achieved for ten of the 12 months of the year. In October 2017 and February 2018, performance fell below expected levels when we suffered a loss of capacity due to equipment failure.

Our environment

Care Without Carbon at SASH

To us, being a sustainable organisation means reaching our vision to pursue perfection in the delivery of safe, high quality healthcare that puts the people in our community first – while at the same time working with three key aims in mind:

1. Working towards long-term financial sustainability
2. Minimising our impact and having a positive impact on the environment
3. Supporting staff wellbeing to enable a happy, healthy and productive workforce

Care Without Carbon (CWC) is our sustainable development management plan (SDMP), setting out how we will achieve this through a seven-step action plan (see below). This ensures we are taking a co-ordinated approach, directly tackling the key challenges in delivering sustainability within the NHS and integrating into our core operational activities across the Trust.



Care Without Carbon at SASH – our seven steps to sustainability.

How we deliver Care without Carbon

The director of information and facilities is the executive lead for and the chief nurse is the clinical lead. Each of the seven action areas is led by a named senior manager, who has responsibility for overseeing the delivery of the action plan for their area and ensures the work is aligned with their department's own strategic priorities and work plans.

To support delivery of our SDMP we commissioned the Sussex Community NHS Foundation Trust (SCFT) Environment and Transformation team to help implement key aspects of the programme, notably energy management foundations and behaviour change work. We have been developing our internal governance procedures for CWC this year and in the coming year we will:

- ✓ Form a multidisciplinary sustainability steering group to oversee the delivery of CWC, including work stream leads and clinical representation

- ✓ Report to our finance and workforce committee quarterly on performance against our SDMP and gain approval from the Board every year
- ✓ Ensure that our SDMP is accessible to our staff and the public through our website and is reviewed and updated annually

Sustainable healthcare across East Surrey and Sussex

In order to further advance our sustainability goals and maximise the benefits, we have broadened our scope to take a more coordinated approach locally. Within East Surrey and Sussex, the annual carbon footprint of our healthcare system including the seven main NHS provider Trusts is around 100,000 tonnes CO₂e, which costs an estimated £32m per annum. As such, we are coming together with NHS provider partners in our Sustainability and Transformation Partnership (STP) area of East Surrey and Sussex to align our sustainability work through the Care Without Carbon framework, an approach originally developed by Sussex Community NHS Foundation Trust (SCFT).

Three collaborative projects have been initiated to date:

- ✓ a joint energy performance contract (EPC) procurement
- ✓ a courier services review
- ✓ a joint waste tender with five of the STP Trusts.

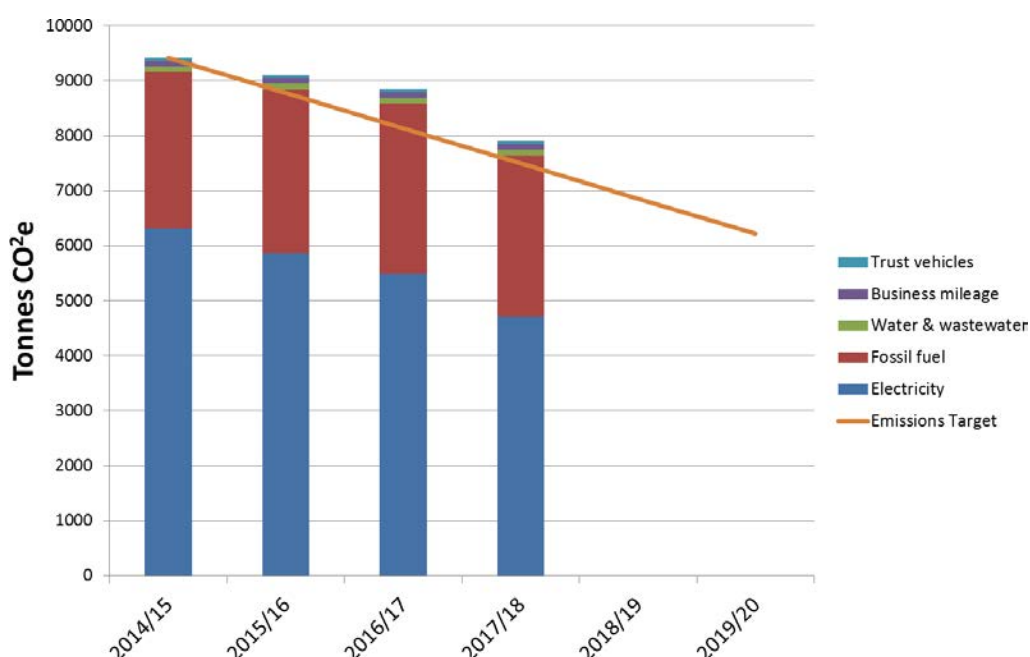
We are also starting to explore the opportunity to roll out a staff engagement and behaviour change programme across the STP area. As well as creating economies of scale and delivering better value, these projects are about sharing best practice, encouraging innovation and improving system-wide planning and management of sustainability impacts.

Our carbon footprint

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also transport Trust staff, patients and goods, and purchase a large range of medical and other equipment and services. All of these activities generate carbon dioxide (CO₂) emissions, which are linked to climate change, and can be collectively summarised as our carbon footprint.

Since our baseline year of 2014-15 we have reduced our absolute carbon footprint by over 1,500 tonnes CO₂e¹ (16%). We are very close to our in-year target for 2017-18, marking our trajectory towards a 2020 target of 34% reduction, in line with national NHS requirements (see below).

¹ CO₂e is the standard unit for measuring carbon footprints. It reflects the impact of all six greenhouse gases that cause global warming including carbon dioxide and methane. This is important as some of the gases have a greater warming effect than carbon dioxide.



SASH carbon emissions

Note: Figures relate to our primary site, East Surrey Hospital only. Due to the date of publication of the annual report, we have estimated some of the data reported here. Scope 3 emissions for waste disposal and procurement (supply chain) are not currently included in our carbon footprint due to lack of reliable conversion factors.

The year ahead

Buildings: providing the workspace for low carbon care delivery with wellbeing in mind.

2020 target: 34% reduction in CO₂e from our buildings

The energy we use to heat, cool and power our buildings is the most significant contributor to our Trust's carbon footprint. We have reduced absolute CO₂e from building related energy consumption by 16% between 2014-15 and 2017-18 (1,512 tonnes CO₂e in total). Current and ongoing work streams include:

- ☐ Working with other local Trusts on the development of an energy performance contract (EPC). This will enable us to focus new investment in our estate and help improve the energy efficiency of our hospital, reducing operating costs and improving the patient environment
- ☐ Thorough review of existing gas and electricity metering, review and update of our BMS, and upgrading our old style fluorescent light fittings to LED. These projects will ensure we are delivering a comfortable working environment for staff and patients, improving our energy efficiency and saving money on bills.

Journeys: maximising the health benefits of our travel and transport activity whilst minimising environmental impacts.

2020 target: 34% reduction in all measurable travel CO₂e

The NHS accounts for five percent of all road traffic in England and travel is responsible for 13 percent of the NHS carbon footprint around 350,000 miles each year with associated cost and carbon impacts. During 2018-19 our specific areas of interest are:

- ☐ implementing recommendations from the sustainability and transformation partnership (STP) courier services review
- ☐ developing a business case for investment in electric vehicle charging points for staff, reintroducing the cycle to work scheme and introducing car sharing
- ☐ developing measurement and reporting processes to track progress against our Travel Plan targets

Procurement: creating and supporting an ethical and resource-efficient supply chain.

2020 target: engage suppliers and procurement partners on delivery of economic, environmental and social outcomes at each step of the procurement process and measure and report on our progress.

Sixty percent of the NHS carbon footprint sits within our supply chain and where there is carbon there's usually avoidable cost. Our procurement action plan takes a whole-life view of the goods and services we purchase, including the end-of-life implications (waste management). Developing our sustainable procurement programme has been a complex challenge, largely due to the difficulty in gathering accurate and detailed supply chain data and will be further developed during 2017-18.

Over the last two years we have introduced the offensive waste stream across East Surrey Hospital, reaching a forecasted rate of 38% (volume of non-infectious healthcare waste as a proportion of total bagged healthcare waste) and delivering significant cost savings.

A priority area of work this year has been our joint waste contract tender across the STP area. Working closely with our STP partners and our chosen contractor, the tender will deliver economies of scale and allow us to progress a number of collaborative waste reduction opportunities e.g. food waste recycling. Over the coming year we will focus on implementing this new contract and working towards the waste targets set out in our SDMP – in particular our target of 75 percent recycling of all our non-healthcare waste.

Culture: informing, empowering and motivating people to take ownership of sustainable healthcare.

2020 target: 100 percent of Trust staff to receive training on sustainability in healthcare, including carbon reduction and climate change adaptation, as appropriate to their role.

We are currently developing a staff engagement programme to raise awareness of this SDMP and drive positive action at every level of the Trust. The first phase of work has included undertaking a staff survey to inform the way we develop staff engagement around sustainable healthcare in 2018/19, updating the SASH intranet to include a new section on sustainability and introducing staff to Care Without Carbon, the idea of sustainable healthcare and what it means at SASH through a series of internal communications. Over the next 12 months we will use the findings of the survey to launch a staff engagement programme based on the successful Dare to Care programme that has been running at SCFT since 2015.

Wellbeing: creating a better working life for our people.

2020 target: reduce sickness rate to 3.5 percent, reduce the percentage of staff reporting that they have suffered work related stress and increase the percentage of staff participating in physical activity during the working day, including active travel to work.

We continue to develop our wellbeing strategy through SASH Active and in-line with the objectives of the SDMP. This incorporates a range of wellbeing initiatives including:

- ☐ book club
- ☐ the choir
- ☐ lunchtime walking
- ☐ circuit training
- ☐ therapies

Over the coming year we will consider the evidence for a wellbeing coordinator to support the delivery of wellbeing initiatives for staff.

Adaption: working together to ensure our infrastructure and operations are resilient to climate change.

2020 target: annual climate change adaptation assessment undertaken as routine component of resilience and business continuity procedures.

With climate in the UK changing, it is important to ensure that health and care system services and infrastructure are prepared for and resilient to the rising temperatures, flooding and other severe weather events that are becoming more and more frequent.

Our adaptation programme will be further developed in 2018/19, focussing on working with our STP partners on developing a system-wide strategy based on a shared understanding of local climate change risks and likely impacts on our individual Trust services.

Governance: maximising the benefits for every area of Trust operations and for our staff and patients through effective governance.

2020 target: publish an annual sustainability report tracking progress against this SDMP and in particular showing how the key SDMP targets are being met.

Effective governance is critical to ensuring that we deliver on our SDMP, integrating and embedding its principles and processes throughout the Trust and engaging our staff, patients and wider stakeholders. This year we have put in place the primary programme governance structures required to deliver this SDMP including establishing our executive lead and clinical lead for sustainability and our reporting mechanisms, both internally and to the Board. Further information on our internal governance and delivery is detailed earlier.

Accountability report

We remain committed to ensuring that our governance systems and arrangements are cohesive and ensure that our approach is co-ordinated and combined. Our directors' report follows:

Our Board of directors

Our Board of Directors consists of five voting executive directors and six non-executive directors (including the chair) and meets every month in public. The minutes and papers are made freely available and this includes publishing them on our website: www.surreyandsussex.nhs.uk/boardpapers

The Board also meets for Board seminars on a regular basis.

There are two additional non-executive directors and three additional executive directors who are non-voting. Voting rights apply should the Board be unable to reach a consensus on a specific issue.

Membership of the Board of directors

- A non-executive chair with a second and casting vote if necessary
- Five non-executive directors
- Designate non-executive director (non-voting)
- Associate non-executive director (non-voting)
- The chief executive and accountable officer
- Chief finance officer and deputy chief executive
- Chief operating officer
- Medical director
- Chief nurse
- Director of information and facilities (non-voting)
- Director of corporate affairs and company secretary (non-voting)
- Director of people and organisational development (non-voting)

Other senior employees attend as the Board of Directors considers appropriate. The Board of Directors provides assurance and leadership of the Trust towards the achievement of corporate objectives and oversight of the framework of sound internal controls, risk management and governance in place to support their achievement.

The Board of Directors is responsible for:

- setting the Trust's strategic aims
- setting the Trust's values and standards
- ☐ the safety and quality of services
- ☐ holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of internal control are robust and reliable
- ☐ ensuring that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives and periodically reviewing management performance
- ☐ ensuring that the Trust complies with these rules of procedure; standing orders; standing financial Instructions; scheme of delegation and statutory obligations at all times

Board members: statement of director responsibilities and declarations of interest

Non-executive directors (NEDs): Non-executive directors have a wide variety of experience in the voluntary, public and private sectors. They are all part-time. Their declarations of interest for 2017-18 are:

Alan McCarthy, chair

- Chair of Charity Commissioning Performance for 'Sick' Festival

- ☐ Trustee of Brighton Dome and Festival Board
- ☐ Vice-chair Brighton Aldridge Community Academy
- ☐ Trustee of Albion in the Community
- ☐ Expert advisor to London Borough of Camden on Chalcots Estate Review

Richard Durban, vice-chair and chair of finance and workforce committee (until 31 December 2017)

- ☐ Magistrate (Justice of the Peace) on Surrey Bench

Richard Shaw, chair of safety and quality committee

- ☐ Governor of Brooklands College of Further Education

Paul Biddle, chair of audit and assurance committee

- ☐ Non-executive director W&J Linney Ltd
- ☐ Non-executive director CAF Bank (until June 2017)
- ☐ Trustee, Macfarlane Trust

Pauline Lambert, senior independent non-executive director

- ☐ Part-time Clinical Paediatric Safeguarding Named Nurse at Queen Victoria Hospital NHS Foundation Trust

Caroline Warner, (Designate non-voting), chair of charitable funds committee

- ☐ Councillor Tandridge District Council
- ☐ Member Consumer Council for Water
- ☐ Member Fairchildes Academy Community Trust

David Sadler, chair of finance and workforce committee (from 1 January 2018)

- Owner/director – David Sadler Advisory Ltd
- ☐ Director Coach Associates Ltd

Daphnee Pushparajah, (Associate non-voting)

- ☐ Director of Vaneal Ltd Associate Director of Engagement - UCB (global biopharmaceutical company)

Executive directors

The executive directors are all full-time employees of the Trust. Details of their remuneration can be found in the remuneration report section of this report.

Michael Wilson CBE, chief executive

- ☐ Special Advisor for the Care Quality Commission (CQC)
- ☐ Honorary President of the East Surrey Branch of the NHS Retirement Fellowship
- ☐ CEO representative on the Programme Board for Health Education England

- ☐ Visiting Professor at Surrey University
- ☐ Member of the Health Education England Tele-enhanced Learning Programme
- Member of the National Trust Guiding Board – Virginia Mason Institute Programme
- ☐ CEO Lead for Sussex and East Surrey STP (till Nov 2017)

Paul Simpson, chief finance officer and deputy chief executive

- ☐ Interim Chair of NHS STP Finance Group from 1.04.17

Dr Des Holden, medical director

- ☐ Medical director of Kent, Surrey and Sussex Academic Health Science Network (one day per week)
- ☐ Non-executive director (NED) of South East Health Technology Alliance

Fiona Allsop, chief nurse

- ☐ Specialist advisor, Care Quality Commission (CQC)

Angela Stevenson, chief operating officer

- ☐ Shareholder in Kate Grimes Ltd, Executive Life Coaching

Gillian Francis-Musanu, director of corporate affairs (non-voting member)

- ☐ Home Office Authorised Person (Marriage Registrar): London Borough of Hounslow and City of Westminster

Mark Preston, director of people and organisational development (non-voting member)

- ☐ No declarations

Ian Mackenzie, director of estates and facilities (non-voting member)

- ☐ No declarations

Our clinical chiefs of service are members of the executive committee to ensure the right clinical balance of decision making.

Key committees

The Board of directors has authorised a number of committees to scrutinise aspects of the work of the Trust. Each committee is chaired by a non-executive director with a membership that (apart from charitable funds and the audit and assurance committee which is a non-executive membership) always includes the chief executive.

The terms of reference of each committee sets out the remit of responsibility delegated by the Board of directors and sets out the information requirements of the

committee, how it should interact with the information it receives and use this to reach a conclusion about assurance. Where assurance cannot be robustly established the chair of the committee reports this to the Board of directors.

The Board of directors receives a report from each chair at every public board meeting. On receiving a report that identifies a lack of assurance in relation to an aspect of the business the Board of directors can either hold the chief executive to account (managerial aspects) or seek independent assurance by referring the matter to its audit and assurance committee.

Core Board sub-committee structure

The key functions of the Board sub-committees are:

Audit and assurance committee: Meets a minimum of five times a year to conclude upon the adequacy and effective operation of the Trust's overall internal control system which includes financial and clinical assurance. It is the role of the executive to implement a sound system of internal control agreed by the Board of directors. The audit and assurance committee provides independent monitoring and scrutiny of the processes implemented in relation to governance, risk and internal control and reviews and considers the work of internal and external audit.

The committee shall also review and challenge the Trust's information assurance framework to ensure that there are appropriate controls in relation to data quality.

Nomination and remuneration committee: To appoint and, if necessary, dismiss the executive directors, establish and monitor the level and structure of the total reward for executive directors, ensuring transparency, fairness, consistency and succession planning.

The committee shall receive reports from the chair of the Board of directors on the annual appraisal of the chief executive; and from the chief executive on the annual appraisals of executive directors, as part of determining their remuneration. The committee meets at the request of the chair of the Board and at least twice per year.

Safety and quality committee: Meets monthly and has delegated authority to ensure the on-going development and delivery of the Trust's safety and quality strategy and that this drives the Trust's overall strategy. The duties of the committee shall ensure the implementation, delivery and monitoring of the Trust's quality and clinical strategies. The committee shall also be responsible for managing the safety of patients through ensuring compliance and the implementation of effective internal controls.

Finance and workforce committee: meets monthly to provide oversight of the Trust's business planning, investment policies, and capital programme. The committee is responsible for the following key areas:

- ☐ business planning process including strategic financial and workforce planning
- ☐ approving investment decisions
- ☐ monitoring delivery of significant projects and investments, and any potential business combinations

Charitable funds committee: Meets three times a year to oversee the generation, management, investment and disbursement of charitable funds (SASH Charity) within the regulations provided by the Charities Commission.

The executive committee and executive committee for quality and risk

The executive committee meets weekly and a twice monthly executive committee for quality and risk which is supported by series of subcommittees to consider, on a rolling basis, managerial delivery of the Board of directors' strategy, quality of services provided and the effectiveness of risk management, the delivery and management of all performance and the management of each clinical division.

Five executive sub-committees have been formed to both guide management decisions and provide assurance for safety; responsiveness; clinical effectiveness; patient experience and workforce.

Board assurance framework

The Board Assurance Framework is a key element of the Trust's system of internal control. It provides a clear methodology for the focused management of risks in the delivery of the Trust's strategic objectives.

The executive team oversees and reviews the assurance framework, which is then discussed and challenged at the Trust Board prior to its acceptance. The assurance framework and the Significant Risk Register are presented monthly to the public Board.

Significant risk register

Details all risks on the Trust risk register system that are recorded as significant and link to the Board assurance framework (BAF). The executive committee oversees (through the head of corporate governance) the maintenance and review of the BAF. It is then discussed and challenged at the Trust Board prior to its acceptance. The BAF and significant risk register are presented at each public Board meeting.

Accountability

Each director confirms that they have taken all the steps that ought to be taken as a director in order to make them aware of any relevant information that should be shared with the Board and its auditors.

Directors' membership of Board sub-committees

Audit and assurance committee	Nomination and remuneration committee	Safety and quality committee	Finance and workforce committee	Charitable funds committee
Chair Paul Biddle	Chair Alan McCarthy	Chair Richard Shaw	Chair Richard Durban (31 December 2017) David Sadler (from 1 January 2018)	Chair Caroline Warner
Members* Richard Durban Richard Shaw In attendance Chief finance officer Director of corporate affairs Other members of the executive and non-executive team are invited to attend as and when required	Members* All NEDs In attendance Chief executive director of people and organisational development	Members* Alan McCarthy Pauline Lambert Caroline Warner Chief nurse Medical director Chief operating officer Chief finance officer Clinical chiefs	Members* Paul Biddle David Sadler (until 31 December 2017) Richard Durban (1 January 2018) Daphnee Pushparajah Chief finance officer Director of people and organisational development Director of information and facilities Director of corporate affairs Chief nurse Chief operating	Members* Pauline Lambert Paul Biddle Chief finance officer Chief nurse Director of corporate affairs Director of information and facilities

			officer	
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*As Accountable Officer, the Chief Executive has an open invitation to attend each Board sub-committee

Signed:

Date: 25 May 2018



Michael Wilson CBE
Chief executive

Annual governance statement

1. 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*.

I report to the Chair of the Trust and ensure appropriate systems exist to support the work of the Trust and the Board. I manage and lead the executive team who have clear accountabilities and annual objectives which are drawn from the Trust's strategy.

The Trust has worked in partnership with other health and social care organisations across the local sustainability and transformation partnership (STP), but notably the local Clinical Commissioning Groups (CCGs). The contracts between us provide clarity on our shared priorities and officers of the Trust meet regularly with our CCGs to take forward developments and monitor the delivery of our shared healthcare plans. I also account to NHS Improvement; this body monitors the Trust and intervenes in performance management if there is other adverse information of sufficient importance or the quarterly rating in its single oversight framework requires it. I, and officers of the Trust, regularly meet with officers of NHS Improvement to discuss performance. NHS Improvement has been involved in monthly meetings with the Trust over its performance during 2017-18.

I attend the Health and Adult Social Care Overview and Scrutiny Committees in relevant Council areas to account for the performance of the Trust to the local community and oversee the work of executive officers in the work programme of the Scrutiny Committees. I and the Trust's Chief Finance Officer regularly attend meetings of the STP governing body to discuss performance against national standards, financial management and strategic change.

In preparing this statement I have ensured that it meets the requirements of the Corporate Governance Code (The HM Treasury/Cabinet Office Corporate Governance Code).

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Surrey and Sussex Healthcare NHS 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 Surrey and Sussex Healthcare NHS Trust NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust's capacity to handle risk is based around a clear Risk Management Policy, effective leadership of the risk management process and staff trained and equipped to manage risk in a way appropriate to their authority. The key elements of the Trust's capacity to handle risk are as follows:

- Effective and pro-active leadership is provided by the Board of Directors. In my role as chief executive I have overall responsibility and have delegated accountability to the chief nurse who has responsibility for ensuring the risk policy is implemented throughout the Trust.
- A body of staff under the risk and patient safety lead has Trust-wide responsibility for ensuring the framework of processes, procedures and controls are in place which enables risk to be assessed and managed.
- The Trust monitors its performance on all aspects of quality and risk management and undertakes investigations into any areas where an issue is identified. It works with local partner organisations to ensure risks across the health economy are managed.
- The Trust has nominated risk co-coordinators within each Division to work with the associate directors of operations, clinical chiefs of service, divisional chiefs of nursing and heads of corporate departments to identify and assess risk.
- Staff are trained and equipped to manage risk in a way appropriate to their

authority and duties:

- Staff receive a breadth of risk management information and training at mandatory corporate induction days, ongoing training as part of a mandatory programme and through distribution of relevant documents.
- The Board has implemented a system of annual review of its risk appetite and Board Assurance Framework. At this review the Board discusses and agrees the risk appetite and tolerances that are set for different types of strategic and operational risk. These provide the Board with an opportunity to refresh the principles of risk management and identify key issues.
- Guidelines on the Trust's approach to risk management and the use of the risk register are available on the Trust's staff extranet and are provided to staff who have key responsibilities for risk management as set out in the accountability framework
- The Risk Management Policy is reviewed regularly and promulgated throughout the Trust. The policy describes the risk management training schedule which is mandatory for all staff including at Board level.

3.1 Risk management policy and risk appetite

Risk, or change in risk, is identified, evaluated and controlled as described in the Trust's Risk Management Policy.

The risk evaluation and treatment model is based on a grading matrix of likelihood and consequence. This produces a risk score to enable the risk to be prioritised against other risks. The score, in turn, is linked to a matrix of the cost and responsibility of risk treatment so that either the risk is addressed locally by the division within its resources or it feeds into the organisation wide risk register. The risks are also mapped to the strategic themes and objectives identified within the trust planning process along with the various other initiatives to confirm the score given to a risk.

Risk management is embedded in the activity of the organisation through:

- The Rules of Procedure approved by the Board in January 2011 (updated April 2017) clarifying roles of Board members and defining the role and structure of Board sub-committees
- A clear accountability framework for managing risk from the Accountable Officer downwards as set out in the Risk Management Policy
- The structure of permanent committees, including Board sub-committees (see Section 2)
- The Board Assurance Framework and the Significant Risk Register (significant risks recorded on the Trust risk register)
- The Trust's risk management process takes into consideration the need to manage all types of risk as relevant to key stakeholders and provides one to one competent support and regular training events. The significant risk register is taken from the Trust's risk registers and is reviewed by the

executive committee and presented at the board meeting held in public

- The Trust's performance management framework; compliance with Care Quality Commission standards and registration, information governance rules, health and safety requirements, and those of other regulatory bodies;
- The Trust's internal controls map, which provides management assurance of control and good assurance to the Audit and Assurance Committee (AAC)
- The work of divisional and specialty governance meetings
- The system of local risk coordinators and divisional risk managers

The Board of directors receives details of significant risks through regular Board reports. The finance report records all key financial risks, the performance and quality report records all key operational risks and performance against key clinical quality outcomes.

The Board of directors has developed and agreed its risk appetite which details the principles of risk that the Trust is prepared to accept, seek and tolerate whilst in the pursuit of its objectives (Appendix 1).

The Board actively encourages well-managed and defined risk management, acknowledging that service development, innovation and improvements in quality requires risk taking. This position is based on the expectation that there is a demonstrated capability to anticipate and manage the associated risks as well. This stance is defined by the Boards risk appetite which is reviewed annually and included in reports presented to each board meeting held in public.

3.2 Risk management and organisational learning

Organisational learning is communicated internally through a structure of committees (covering clinical and non-clinical risk) that penetrate throughout the organisation down to local management teams.

Learning is supported by the consistent application of root cause analysis of problems and incidents and the avoidance of blaming individuals for system failures as described in various Trust policies, including the organisation-wide policy for the management, reporting and investigation of incidents including serious incidents (SIs). This has been further improved during the financial year and the Trust has implemented systems to support duty of candour which is driving change in culture. The Trust has a range of problem resolution policies and procedures, including whistle blowing, respect, capability, disciplinary and grievance, which are designed to identify and remedy problems at an early stage.

The Trust has a range of individual support mechanisms to encourage individuals to raise concerns about their own performance in ways which will not threaten their security or livelihood, eg appraisal, alcohol use/abuse policies, professional counselling and occupational health services. The Trust has also appointed a

Freedom to Speak Up Guardian.

The Trust has in place a counter fraud contractor whose services are embedded within the Trust. More details are provided below.

3.3 Data security

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of ten data and cyber security standards, the 2017-18 Data Security Protection Requirements (2017-18 DSPR), that all providers of health and care must comply with.

The 2017-18 DSPR standards are based on those recommended by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by government in July 2017.

The Trust carried out a self-assessment against these standards and submitted the assessment to NHS improvement on 2 May 2018. The questions were designed to test whether we have implemented (fully, partially or not) the ten standards outlined in the 2017-18 DSPR.

The Trust reported full compliance with eight of the standards and two with partial compliance. The trust is working towards achieving full compliance.

A summary of the standards are outlined below:

1. Senior level responsibility for data and cyber security
2. Completing the information governance toolkit v14.1
3. Preparing for the introduction of the General Data Protection Regulation
4. Training staff in data security
5. Acting on CareCERT advisories
6. Comprehensive business continuity plans to support data and cyber security incidents
7. Reporting incidents
8. Identified unsupported systems

All data security risks are added to the Trust risk register and reported in line with the Trust Risk Management Policy.

3.4 Risks to strategy and Significant risks (operational)

The Board of Directors identify and record strategic risk on the Board Assurance Framework (BAF). The BAF at its meetings, the reports received from the Board sub-committees, the Trust significant risk register and any self-assessment exercise required for regulators or commissioners of service. Clinical risks and non-clinical risks are reviewed by the executive committee, The executive committee for quality and risk, the safety and quality committee (SQC) and the Board.

The March 2018, end of financial year, BAF identifies three main strategic risks to the Trust meeting its strategic objectives. These are summarised as follows:

Risk description: 4.2 There is a risk that if the Trust does not deliver the planned efficiencies it will be unable to create the necessary capacity, which will have an adverse impact on elective care, income, expenditure and ultimately quality objectives.			
Current assessment of risk	S5 x L3 = 15	Target risk score	S5 x L2 = 10
Assurances: Positive (+) Delivered surplus in 2016-17 (+) Strong elective performance in March 2017 (+) Strong cancer performance throughout 2016-17 (+) Evidence of positive management of performance alerts Negative (-) Increase in patients with high length of stay (-) Increase in MDT ready patients for discharge (-) Community capacity does not match demand (-) Rehab capacity does not match demand (-) Adult bed occupancy remains high (-) Increase in ambulance conveyance Mitigating actions underway: 1) Full action plan development for productivity programme (theatres, outpatients, SASH+ value streams, length of stay) 2) Delivery of internal actions relating to urgent and emergency care implementation plan			

Risk description: 5.5 There is a risk that the Trust will not meet its objective of becoming an 'employer of choice' if it does not deliver a workforce strategy that drives the recruitment and retention of talent, provides the relevant skill-mix for operational delivery and supports on-going professional education, training and development across all staff groups			
Current assessment of risk	S5 x L3 = 15	Target risk score	S3 x L2 = 6

Assurances:

Positive

- (+) 2017 National Staff Survey response rate was 67% compared to a national response rate of 43% - this was the second highest nationally
- (+) Of 32 Key Findings in the 2017 National Staff Survey results, SASH have scored 25 in the Top 20% nationally, five of which are the highest scores for Acute NHS Trusts
- (+) 2017 AR cycle has met 90% target
- (+) SASH invited to be part of the NHSI Retention Support Programme
- (+) There is an active pipeline of 59 (bands 5/6) registered midwives or nurses due to start with the Trust in the next eight weeks on a direct recruitment basis

Negative

- (-) SASH was in the lowest 20% nationally in the 2017 National Staff Survey for staff experiencing physical violence from patients, relatives or the public and staff experiencing bullying and harassment from patients, relatives or the public
- (-) Nursing recruitment challenging, (including international recruitment issues), with negative effect on bank and agency usage

Mitigating actions underway:

- 1) Action planning from the 2017 National Staff Survey to take place
- 2) 2017-18 achievement review cascade process met required target
- 3) Pro-active recruitment planning in place including international campaigns

Risk description: 5.6 There is a risk that the Trust will not meet its objective of becoming an 'employer of choice' if it does not deliver a workforce strategy that seeks to priorities staff health, safety, well-being, engagement and inclusion.

Current assessment of risk

S5 x L3 = 15

Target risk score

S3 x L2 = 6

Assurances:

Positive

(+) National frameworks in place to support local delivery (eg Health CQUIN, WRES, etc.)
(+) The 2017 flu vaccination campaign has met the CQUIN target of 70% of frontline staff being vaccinated by 31st December 2017
(+) The 2017 National Staff Survey reported a 67% response rate

Negative

(-) SASH was in the lowest 20% nationally in the 2017 National Staff Survey for staff experiencing physical violence from patients, relatives or the public and staff experiencing bullying and harassment from patients, relatives or the public

Mitigating actions underway:

- 1) Individual strategies with objectives and action plans being drafted for approval
- 2) 2017-18 CQUIN actions and objectives being monitored
- 3) Collaborative working with external partner is being undertaken to support mental health awareness for staff and managers

Each BAF risk includes details of the controls in place, gaps in controls and mitigating actions identified by the Executive lead to reduce the severity or likelihood of the risk impacting on delivery of the Trust's identified risk to its strategic objectives. BAF risks are discussed in detail at both public Board and the Audit and Assurance Committee.

Similarly the Trust records non-strategic risk on its risk register. These risks are operational in nature and can be particularly short-term in nature. At the end of the financial year the Trust had recorded the following significant risks. These are discussed and monitored in detail by the executive committee and its subcommittee and reported to public Board and the Audit and Assurance Committee. (see section 10.1 Significant Internal Control Issues).

Risk title	Current Rating	Residual Rating
Failure to maintain Emergency Department performance	S4 x L5 = 20	S4 x L3 = 12
RTT Access Standards	S3 x L5 = 15	S3 x L2 = 6
Ambulance Handover Delays	S4 x L5 = 20	S4 x L3 = 12

4. Quality governance

The Trust uses an internally developed system to monitor all aspects of performance and quality. This takes the form of a regular report based on the Department of Health's and NHS Improvement performance indicators, and the monthly finance report as part of the integrated performance report. These reports detail the Trust's sustained improvements in safety and the challenges that have been faced throughout the winter pressures that have affected the hospitals effectiveness and performance.

The Trust has developed a series of performance management systems that monitor individual elements of performance and trigger actions. For example there is a set of reports available to the Board on a regular basis which monitor performance in all key business areas of the organisation. Performance reports demonstrate that action is taken, both at the executive committee (and its sub committees) and at operational meetings to address variances from objectives, standards and targets. Where variance is identified, action plans are established to address them and reviews of action plans undertaken to ensure that the desired results are achieved. These are monitored by division specific performance meetings.

There is a visible process, and hierarchy, within the organisation of performance management at each level of the Trust that is coherent and amalgamated into Board level performance reports.

Each division has a governance group which reports to and can be instructed by the five executive sub-committees for quality and risk. Output of the executive committee for quality and risk is a standing item on the Safety and Quality Committee (SQC) agenda as is a report from the CCGs Clinical Quality Review Group (CQRG). This allows the board through the SQC Chair monthly report to ask for further work or seek further clarification on issues raised or supporting agenda items such as patient stories or the Integrated Performance and Quality Report (IPQR), Delivering our Vision.

Divisional teams also have a simple process for escalating issues from divisional governance thorough the relevant sub-committees of the executive committee for quality, risk and up to the SQC and public Trust Board. This is supported by the Trust's incident reporting system and when necessary the whistleblowing policy.

4.1 Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

This details the Trust's performance against a series of quality indicators and details the Trust's plans to continually improve the quality of its services. This is developed

internally and shared with our local health partners before publication and submission to NHS England. The executive team provides me with assurance and regular updates on the drafting of the account. I gain assurance that the quality account is developed appropriately from external audit.

4.2 Data quality, elective waiting time and cancer 62 day access standards

Assurance of elective waiting time data is provided through the Trust's overarching data quality framework which, in relation to elective waiting times, includes

- Training of front system users in both system usage and elective waiting time rules
- Well-established data quality team in relation to RTT(referral to treatment)
- Elective waiting times included in the internal audit programme

Historic risks in relation to RTT tracking systems/data have been significantly mitigated during 2017-18 when the Trust completed a migration of RTT reporting from an in-house system to one which is integrated and provided by the Trust's electronic patient record supplier. As well as providing more resilient data, the migration included the validation of over 100,000 RTT pathways with a low error rate identified. While some residual risk remains, this is known and not significant and will be further reduced with further upgrades to the EPR that are planned for 2018-19.

The internal audit programme in 2017-18 looked at cancer 62 day performance, internal audit reviewed the Trust's systems for monitoring this data and provided substantial assurance that data is captured appropriately and accurately reported to the Board and externally.

5. Compliance with CQC registration

The Trust was inspected by the CQC in May 2014 and received an overall Good rating across all elements of quality; safe, caring, effective, responsive and well-led.

The inspection team highlighted elements of outstanding care in their report and the Trust maintains its position in the lowest risk banding on the CQC intelligence monitoring profile.

In terms of the eight core services that were reviewed the Trust received a good rating for all services apart from outpatients services which were rated as requires improvement. The Trust implemented an action plan with four key work streams to improve the quality of outpatient services; environment, workforce and leadership skills, communications and systems and processes. These issues have now been resolved and re-inspected by the CQC in January 2016 and confirmed that the requirements identified in the last inspection have been met.

The Executive Committee for Quality and Risk (ECQR) formally reviews compliance

against the CQC key lines of enquiry regularly and has developed a series of domain and service level action plans to maintain and develop service in line with requirements and best practice. This is reported to the Safety and Quality Committee. The Trust strives to achieve an outstanding rating in its next inspection. The ECQR, domains and services regularly review the CQC Insight report and takes into account the information included in national data.

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

6. Well led

The Board regularly reviews a self-assessment of its ability to lead the Trust using guidance published by the NHS Improvements and CQC on the Well Led Framework. This self-assessment review highlights no areas of significant concern but identifies areas of continuous improvement.

Visits from the Secretary of State for Health and Social Care provided strong assurance of the Trust's leadership. This is triangulated with significant feedback on the culture and leadership from senior colleagues from NHS Improvement, the CQC and previous external review of the previous BGAF and QGAF.

Similarly the executive team regularly carries out a self-assessment of the Trust's leadership using the key lines of enquiry developed by the CQC.

The Trust is developing plans to carry out an external well led review in 2018-19.

7. NHS provider licence

Surrey and Sussex Healthcare NHS Trust is able to confirm full compliance with all relevant aspects of the NHS provider licence as they relate to non- Foundation NHS

Trusts. The Board has reviewed the conditions of the licence including condition four and is able to confirm compliance with the following:

- there are effective and robust of governance structures in place
- there are clear responsibilities of directors and subcommittees
- there are clear and robust reporting lines and accountabilities between the Board, its subcommittees and the executive team
- the Trust submits timely and accurate information to assess risks to ensure compliance with the conditions of the licence
- the Board has consistent and systematic oversight the of the Trust's performance through its accountability framework

The Board is responsible for providing effective and proactive leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed.

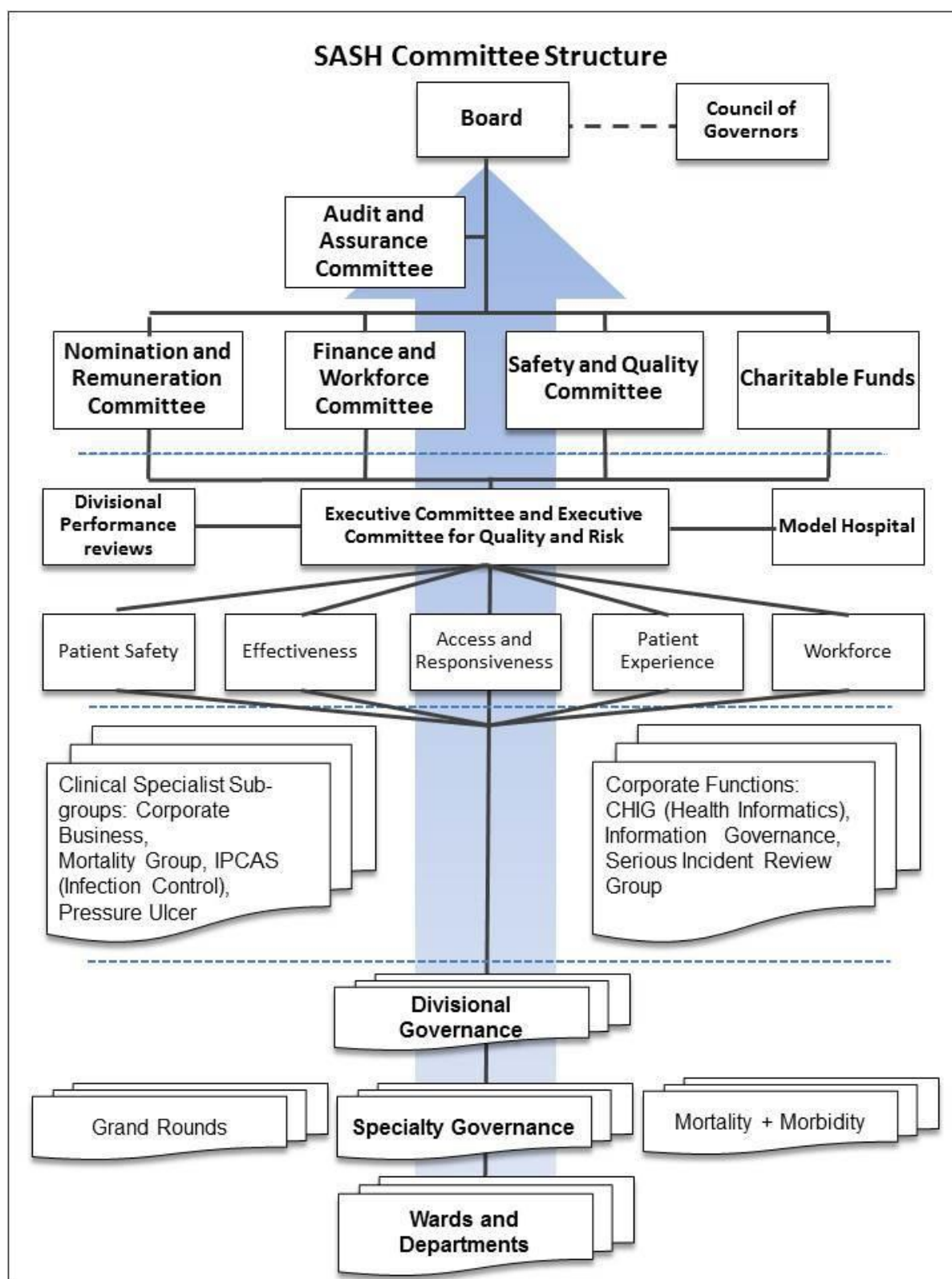
The Board governs the Trust business, including the delivery of the strategies it sets by seeking assurance that the managerial systems that are in place deliver the desired outcomes and enable effective and timely reporting of significant issues that threaten its objectives.

I have aligned and delegated accountability (see Section 1 above) and decision making authorities to the line management structures in place that deliver the day to day business. This alignment provides all staff and the Board of directors with a simple and well understood way of:

1. ward/operational reporting to Board relevant issues
2. the Board disseminating its strategy and objectives to the wards and operational services

Through this structure those with the authority can exercise it and there are clear escalation processes if they are unable to do so. The escalation processes lead to individual directors and the Trust's executive committee which I chair as the Accountable Officer. It further allows staff to see where they fit in the overall strategy and how their personal objectives support the Trust to deliver its objectives.

The governance framework and the escalation framework for the Trust are described in the diagrams below.



The Audit and Assurance Committee have scrutinised the board assurance framework and added value to the description of strategic risks, provided strong challenge to the management and recording of financial risk and influenced how the Board looks at sustainability and transformation plans and action relating to the ongoing impact of the challenged financial environment that the NHS faces.

8. Governance matters

8.1 Information governance

Information governance is a framework for managing information, particularly personal information of patients and employees. It should ensure that personal information is dealt with legally, securely, efficiently and effectively. The Department of Health provides the standards and a self-assessment tool-kit and Trust's compliance is measured according to the indicators in the tool-kit. The Care Quality Commission is informed of the Trust's results.

Our aim is to improve our compliance year on year and a key element in achieving this is ensuring that all staff receives annual training and regular updates relating to Information Governance and data security.

All information governance risks are added to the Trust risk register and reported in line with the Trust Risk Management Policy. The Trust has not identified any information governance serious incidents during the financial year.

There are processes in place for incident reporting and investigation of serious incidents. During 2017-18 all reported information governance incidents were of minor significance.

The Trust has taken the necessary action to ensure plans are in place to support the implementation of the general data protection regulations from May 2018.

8.2 NHS Pension Scheme

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

8.3 Human rights and equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. (See the equality, diversity, human rights section of the annual report)

8.4 Carbon reduction delivery plans

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

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

9.1 Financially

The Trust has delivered a £13.6 million surplus in 2017-18, and has a small recurrent surplus underlying that position. This is the second concurrent year that the Trust has delivered a surplus. The Trust has a reference cost index of 83 and Model Hospital data describes the lowest acute trust cost per weighted activity unit (£2,930 per WAU) nationally. These values represent improvement on the last year.

The Trust has an embedded budgeting and cost improvement process, an embedded financial reporting process and performance management structure. The latter consists of monthly meetings with divisions, monthly reporting to executive committee, finance and workforce committee and Board. There is a monthly capital group and similar monthly reporting to the same groups. Standing financial instructions and financial procedures are in place and were updated in-year.

The Audit and Assurance Committee reviews management opinion of internal controls systems for resource management (and did so during 2017-18, stating assurance) and audits from internal audit and external audit. All internal audit reports have provided full assurance in relation to finance areas during the year. The 2017-18 external audit report will be received after this annual governance statement is written but in the 2016-17 audit, auditors gave the Trust an unconditional value for money conclusion on 2 June 2017. That stated that auditors were satisfied that the Trust had put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources.

9.2 Efficiency and effectiveness

The Trust has embedded a number of key processes and change programmes to deliver continuous improvement, greater efficiency and effectiveness. These include the examples below:

- **SASH+**: Over the last two years SASH, along with four other Trusts, has been working in partnership with the Virginia Mason Institute (VMI) in Seattle, USA who have developed a transformational management system - the Virginia Mason Production System which is based on lean methodological improvement techniques adopted and adapted from the Toyota car manufacturing factory in Japan. Over the last 17 years the production system has enabled them to become one of the safest and highest rated hospital organisations in the USA.

Reflecting the Japanese history of the programme some of the references and language used are Japanese in origin, for example: **Kaizen** (continuous incremental improvement) and **Genba** (the place where the work is done).

Our aim at SASH is to pursue perfection, putting our patients at the forefront of everything we do, improving safety and quality by reducing variation and waste in every process. Our SASH+ work supports an accelerated transformation in quality by providing us with a structured approach to continue our improvement journey taking us from a good to an outstanding organisation.

By focusing on the elimination of waste our SASH+ improvement methodology has helped us to become more efficient and reduce costs but more importantly it has begun to engender a culture of continuous improvement where staff on the genba are taking responsibility to improve their service on a daily basis. SASH+ is an enabler to delivering our cost improvement programme and has successfully identified opportunities for additional income, reduction in costs and improved efficiency.

- **Model Hospital Group**: initiated during 2017-18 and chaired by the CEO. The forum works through Model Hospital data with relevant specialities and departments to understand and address, where appropriate, areas of unwarranted variation. The outputs of this provide clinical and operational direction as well as action around finance (such as cost improvement programmes). The Trust is engaging actively in the GIRFT programmes (Getting It Right First Time – national improvement programmes based around consistency in clinical specialties) and has successfully delivered against a series of action plans put in place as a result of these reviews. The GIRFT programme for 2018-19 will be more extensive and expand into medical specialties, which is welcomed. The Model Hospital Group reports

directly to the executive team and an overview of activities and successes are reported to the Finance and Workforce Committee.

- Elective productivity programme: the chief operating Officer manages a formal elective productivity programme based around Theatres, outpatients, and endoscopy that is reported to the Finance and Workforce Committee.
- Quality and productivity benchmark report: Each quarter the Trust provides a benchmark report to the Board that combines productivity, effectiveness and quality data and compares the Trust to its peer group.
- Committee structure: the internal structure of monthly committees that supports the Executive Committee for Quality and Risk (Effectiveness, Patient Safety, Patient Experience, Access and Responsiveness and Workforce) provides the governance around each of these areas and incorporates efficiency and effectiveness within their coverage.

10. Review of effectiveness of internal control

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 committee, the Safety and Quality Committee and Finance and Workforce Committee (FWC) and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed in a number of ways.

- Executive directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.
- The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Internal audit reports have been targeted at a broad range of areas to identify issues and

the head of internal audit opinion has not identified any 'no assurance' opinion reports in 2017-18.

- The head of internal audit opinion which states:
'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.
- External auditors provide me with assurances through their opinion on the financial statements, their value for money conclusion and the external auditor's report on the annual quality account.
- Other external organisations, including the NHS Improvement, the Care Quality Commission, MHRA, other agencies of the Department of Health and Social Care, our commissioners and private consultancy companies commissioned by the Trust, have provided me with reports about controls, compliance with standards, financial management and performance in delivering targets.
- The Trust's Audit and Assurance Committee (AAC) is constituted to provide the Board of directors with an independent and objective review of its systems of internal control, financial information and compliance with laws, guidance and regulations governing the NHS. As such throughout the financial year the AAC has gained assurance and driven improvements in controls from reviews of the Trust's internal control systems for financial controls, risk management, data quality, workforce and clinical governance.
- The AAC has gained strong assurance from external audit relating to the completion of the final audited accounts and value for money and have received independent assurance from internal audit on a series of controls both corporate and clinical. The Committee continues to receive and consider internal and independent assurances and has adopted the 'three lines of defence' model to provide context and depth of assurance.

10.1 Significant internal control issues

As described in the risk management section above there are elements of performance against national standards that were not achieved in year. Despite having robust internal control systems the most notable is under-performance against national standards for the emergency department four hour standard which has not been delivered nationally over the course of the year. In addition, and highlighted in the operational risks, is the national standard for referral to treatment for elective patients. Our performance is detailed in the performance section of the annual report.

The Trust is actively working across the health system to ensure the safety of services and delivery of national standards. There has been significant focus on the delivery of ED performance with developments of infrastructure and pathways (Kingsfold (Ambulatory) Unit, GP streaming) which have seen the Trust's ED performance rank amongst the highest in the country over one of the busiest winter the NHS has known. In addition, plans put in place during 2017-18 to support RTT are reflected in reductions in patients waiting over 18 weeks over the second half of

the year - 2,685 patients at the end of March 2018 compared to a peak of 3,751 patients at the end of September 2017.

I record these as significant control issues, but it should be noted that the Trust's performance against these standards are interlinked with surrounding community services and the cross boundary pathways and resources in place. The Trust continues to work internally and with its partners to develop internal controls and system wide pathways to improve delivery of high quality care to our community.

11. Conclusion

With the exception of the internal control issues listed above, my review confirms that Surrey and Sussex Healthcare NHS Trust has a sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed



Michael Wilson CBE

Chief Executive

Date: 25 May 2018

Appendix 1: Risk Appetite – 2017-18

The Board of Directors has developed and agreed the principles of risk that the Trust is prepared to accept, seek and tolerate whilst in the pursuit of its objectives.

The Board actively encourages well-managed and defined risk management, acknowledging that service development, innovation and improvements in quality requires risk taking. This position is based on the expectation that there is a demonstrated capability to anticipate and manage the associated risks as well. The key following principles further define this stance with an opinion from the Board:

Quality: The quality of our services, measured by clinical effectiveness, safety, experience and responsiveness is our core business. We will only put the quality of our services at risk only if, upon consideration, the benefits of the risk to improve quality are justifiable and the management controls in place are well defined and practicable. **Target: Green**

Innovation: The Trust is highly supportive of service development and innovation and will seek to encourage and support it at all levels with a high degree of earned autonomy. We recognise that innovation is a key enabler of service improvement and drives challenge to current practice both internally and across the wider health economy. **Target: Amber**

Well Led: The Board acknowledges that healthcare and the NHS operates within a highly regulated environment, and that it has to meet high levels of compliance expectations from a large number of regulatory sources. It will meet those expectations within a framework of prudent controls, balancing the prospect of risk reduction and elimination against pragmatic operational imperatives. The Board will seek to innovate and take risks where there is potential to develop inspirational leadership as it recognises that this is key to both becoming the local employer of choice and developing strategic partnerships with new bodies. **Target: Green**

Financial: The Trust is prepared to invest for return and minimise the possibility of financial loss by managing risk to a tolerable level. The Board will take decisions that may result in an adverse financial performance rating in the face of opportunities that balance safety and quality and are of compelling value and benefit to the organisation. The Board acknowledges that financial challenges throughout 2017-18 will be significant and there will be an expectation of aggressive risk reduction strategies and increased scrutiny of mitigating actions. **Target: Amber**

Reputation: The Board is prepared to take decisions that have the potential to bring scrutiny of the organisation by our internal or external audiences, provided that potential benefits outweigh the risks and by prospectively managing any reputational consequences. **Target: Green**

Workforce: The good will of our staff is important to the Trust. Any decision that places at risk or has the potential to adversely affect the working lives of our employees will be balanced very carefully against any potential benefits. The Board recognises the complications attached to recruitment, retention and skill-mix that are caused by geographical and national position. **Target: Green**

Signed



Michael Wilson CBE
Chief Executive

Date: 25 May 2018

Remuneration and staff report

This report includes details regarding senior managers' remuneration in accordance with Section 234b and Schedule 7a of the Companies Act. We have an established Nomination and Remuneration Committee to advise and assist the Board in meeting our responsibilities to ensure appropriate remuneration, allowances and terms of service for the chief executive and directors. Membership of the Committee comprises of the Trust chair and non-executive directors. The chief executive or the other executive directors can be invited to attend in an advisory capacity (except in relation to their own terms and conditions). The director of people and organisational development attends the committee as adviser and is responsible for taking minutes of the meetings. The chief executive and directors' remuneration is determined on the basis of reports to the remuneration committee taking account of any independent evaluation of the post, national guidance on pay rates and market rates. Pay rates for other senior managers are determined in accordance with Agenda for Change job evaluations and central NHS review body pay awards. Pay rates for the chair and non-executive directors of the Trust are determined by the Secretary of State and outlined in NHS Improvement guidelines.

We do not operate any system of performance related pay. The performance of non-executive directors is appraised by the chair. The performance of the chief executive is appraised by the chair. The performance of Trust executive directors is appraised by the chief executive.

The chief executive and all directors are on permanent contracts as at 31 March 2018 and subject to six months' notice period. Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements and the NHS pension scheme. Tables attached show details of

salaries, allowances and any other remuneration and pension entitlements of senior managers. No significant awards have been made in the past year to senior managers.

Please note that the section below is subject to audit.

Please see remuneration and pension disclosure tables below:

NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury) 2017-18

Name		Title	2017-18					
			(a) Salary and Fees (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Executive Directors								
Allsop, Mrs. Fiona Margaret	Chief Nurse	***125-130				27.5-30	155-160	
Francis-Musanu, Mrs. Gillian Josephine	Director of Corporate Affairs	**90-95				32.5-35	125-130	
Holden, Dr Desmond Philip	Medical Director	135-140		10-15		0	150-155	
Mackenzie, Mr. Ian Duncan	Director of Information and Facilities	100-105				17.5-20	120-125	
Preston, Mr Mark	Director of Organisation Development and People	105-110				27.5-30	130-135	
Simpson, Mr. Paul Fraser	Chief Financial Officer	135-140				20-22.5	155-160	
Stevenson, Mrs Angela	Chief Operating Officer	120-125	1			30-32.5	150-155	
Wilson, Mr. Michael Anthony	Chief Executive	*200-205	1			0	200-205	
Non-Executive Directors								
Biddle, Mr. Paul	Non-Executive Director	5-10	4				5-10	
Durban, Mr. Richard Don	Non-Executive Director	5-10	3				5-10	
Lambert, Ms. Pauline	Non-Executive Director	5-10	3				5-10	
McCarthy, Mr. Alan Roy	Chairman	30-35	4				35-40	
Sadler, Mr. David	Non-Executive Director	5-10					5-10	
Shaw, Mr. Richard Oliver	Non-Executive Director	5-10	2				5-10	
Warner, Mrs. Caroline	Non-Executive Director	5-10	1				5-10	
Band of Highest Paid Director's Total Remuneration (£'000)		200-205						
Mid Point of the Banded Total Remuneration of Highest Paid Director (£'000)		£202,500	Notes					
Median Total Remuneration		£25,551	* In the salary figure there is a payment of £5,000.01 that relates to 16/17 pension adjustments					
			** In the salary figure there has been a deduction of £2,903.23 that relates to unpaid A/L taken in the 16/17 financial Year					
			*** In the salary figure there is a payment of £7,467.49 that relates to 16 days of untaken annual leave					
Ratio		7.93						

Notes

* In the salary figure there is a payment of £5,000.01 that relates to 16/17 pension adjustments

** In the salary figure there has been a deduction of £2,903.23 that relates to unpaid A/L taken in the 16/17 financial Year

*** In the salary figure there is a payment of £7,467.49 that relates to 16 days of untaken annual leave

NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury) 2016-17

Name	Title	2016-17					
		(a) Salary and Fees (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Executive Directors							
Allsop, Mrs. Fiona Margaret	Chief Nurse	120-125				30-32.5	145-150
Francis-Musanu, Mrs. Gillian Josephine	Director of Corporate Affairs	90-95				12.5-15	100-105
Holden, Dr Desmond Philip	Medical Director	135-140			*25-30	0	165-170
Mackenzie, Mr. Ian Duncan	Director of Information and Facilities	100-105				15-17.5	115-120
Pink, Mr Colin	Director of Corporate Affairs (Interim)	0-5				2.5-5	5-10
Preston, Mr Mark	Director of Organisation Development and People	105-110				130-132.5	230-235
Simpson, Mr. Paul Fraser	Chief Financial Officer	135-140				37.5-40	170-175
Stevenson, Mrs Angela	Chief Operating Officer	120-125	1			142.5-145	260-265
Wilson, Mr. Michael Anthony	Chief Executive	170-175	2			5-7.5	180-185
Non-Executive Directors							
Biddle, Mr. Paul	Non-Executive Director	5-10	2				5-10
Durban, Mr. Richard Don	Non-Executive Director	5-10	2				5-10
Hall, Mr. Alan J	Non-Executive Director	5-10					0-5
Lambert, Ms. Pauline	Non-Executive Director	5-10	2				5-10
McCarthy, Mr. Alan Roy	Chairman	30-35	5				30-35
Sadler, Mr. David	Non-Executive Director	0-5	0				0-5
Shaw, Mr. Richard Oliver	Non-Executive Director	5-10	2				5-10
Warner, Mrs. Caroline	Non-Executive Director	0-5	1				0-5
Band of Highest Paid Director's Total Remuneration (£'000)		180-185					
Mid Point of the Banded Total Remuneration of Highest Paid Director (£'000)		£182,500		Notes			
Median Total Remuneration		£25,298		* Represents Clinical Excellence Award			
		7.21					
Ratio							

NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury): pension benefits 2017-18

Name	Title	(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total Accrued Pension at pension age at 31 March 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000)	(e) Cash Equivalent Transfer Value at 1 April 2017	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2018	(h) Employer's contribution to stakeholder pension	(i) Total pension entitlement at 31 March 2018 (bands of £5,000)
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Allsop, Mrs. Fiona Margaret	Chief Nurse	0-2.5	-	15-20	5-10	286	42	328	18	15-20
Stevenson, Mrs Angela	Chief Operating Officer	0-2.5	0-2.5	45-50	115-120	659	78	736	17	45-50
Francis-Musanu, Mrs. Gillian Josephine	Director of Corporate Affairs	0-2.5	5-7.5	35-40	105-110	660	64	724	13	35-40
Mackenzie, Mr. Ian Duncan	Director of Information and Facilities	0-2.5	2.5-5	40-45	125-130	839	85	924	15	40-45
Simpson, Mr. Paul Fraser	Chief Financial Officer	0-2.5	5-7.5	25-30	80-85	528	72	600	20	25-30
Preston, Mr Mark	Director of Organisational Development and People	0-2.5	0-2.5	30-35	70-75	452	56	508	15	30-35
NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury) 2018		1.01	1.00%							

Remuneration notes:

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

The banded remuneration of the highest paid director within the Trust in the financial year 2017-2018 is £200,000-£205,000. This approximates to 7.93 times (2016-17, 7.21 times) the median remuneration of the workforce, which is £25,551 (2016-17 £25,298).

In 2017-18 seven employees received remuneration in excess of the highest paid director. In 2016-17 nine employees were paid in excess of the highest paid director. Remuneration ranged from £15,404 to £269,402. In 2016-17 the range was £15,251 to £265,821.

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

The number of employees based on the average number of WTE (whole time equivalent including temporary staff) at the Trust rose from 4,025 in 2016-17 to 4,161 in 2017-18.

Please note that the sections below are not subject to audit.

Exit packages and severance payments

Reporting of other compensation schemes - exit packages 2017-18	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No.	£000	No.	£000	No.	£000	No.	£000
Exit package cost band (including any special payment element)								
Less than £10,000								
£10,000 - £25,000								
£25,001 - 50,000								
£50,001 - £100,000			1	51	1	51		
£100,001 - £150,000								
£150,001 - £200,000								
More than £200,000								
Total			1	51	1	51		

Reporting of other compensation schemes - exit packages 2016-17	Number of compulsory redundancies No.	Cost of compulsory redundancies £000	Number of other departures agreed No.	Cost of other departures agreed £000	Total number of exit packages No.	Total cost of exit packages £000	Number of departures where special payments No.	Cost of special payment element included in £000
Exit package cost band (including any special payment element)								
Less than £10,000								
£10,000 - £25,000			2	25				
£25,001 - 50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
More than £200,000								
Total			2	25				

	Number of Package Agreements 2017-18 No.	Total value of agreements 2017-18 £000	Number of Package Agreements 2016-17 No.	Total value of agreements 2016-17 £000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice			2	25
Exit payments following employment tribunals or court orders	1	51		
Non-contractual payments requiring HMT approval (special severance payments)*				
Total**	1	51	2	25
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary				

Staff Report

Staff numbers and costs

Average number of employees (WTE basis)	Total Number	Permanent Employed Number	Other Workers Number	Total Costs	Permanent Staff Costs	Other Workers Costs
	WTEs	WTEs	WTEs	£'000	£'000	£'000
Medical and dental	612	565	47	63,502	56,576	6,926
Ambulance staff						
Administration and estates	838	721	117	37,585	32,520	5,065
Healthcare assistants and other support staff	889	769	120	15,611	12,371	3,240
Nursing, midwifery and health visiting staff	1,333	1,051	282	63,192	46,068	17,124
Nursing, midwifery and health visiting learners						
Scientific, therapeutic and technical staff	405	374	31	13,543	13,245	298
Healthcare science staff	84	84		4,493	4,493	
Social care staff						
Agency and contract staff						
Bank staff						
Other						
Total average numbers	4,161	3,564	597	197,926	165,273	32,653

Of which number of employees (WTE) engaged on capital projects	4	4			250	
--	---	---	--	--	-----	--

Staff composition

Staff composition	Total Numbers	Permanent Employed Number	Other Workers Number	Female Number	Male Number
Directors	8	8		2	6
Medical and dental	612	565	47	313	299
Ambulance staff					
Administration and estates	830	713	117	604	226
Healthcare assistants and other support staff	889	769	120	693	196
Nursing, midwifery and health visiting staff	1,333	1,051	282	1,218	115
Nursing, midwifery and health visiting learners					
Scientific, therapeutic and technical staff	405	374	31	336	69
Social Care Staff					
Healthcare Science Staff	84	84		56	28
Other					
TOTAL	4,161	3,564	597	3,222	939

Staff engaged on capital projects (included above)	4	4		2	2
--	---	---	--	---	---

Staff sickness absence

Staff sickness absence	2017-18 Staff sickness absence Number	2016-17 Staff sickness absence Number
Total days lost	27,219	26,252
Total staff years	3,752	3,449
Average working days lost (per WTE)	7	8
No of early retirements on the grounds of ill-health	2	4
Value of early retirements on the grounds of ill-health	101	228

Audit report

The detailed audit report is included in the annual accounts.

Putting people first

‘Every day I see the hard work and absolute commitment to the people we care for from everyone at Surrey and Sussex Healthcare NHS Trust and their professionalism and focus on making a difference to our patients.

I see colleagues working together as one team and, when times are challenging, it makes me proud to see and know the difference they make to each other and the people we care for.

I thank them all for the care and compassion they continue to show our patients each and every day.’



Michael Wilson CBE

Chief executive

Surrey and Sussex Healthcare NHS Trust

Keep in touch

Surrey and Sussex Healthcare NHS Trust

Trust Headquarters
Canada Avenue
Redhill
Surrey
RH1 5RH
01737 768511
enquiries@SASH.nhs.uk
www.surreyandsussex.nhs.uk
Twitter: @SASHnhs

Surrey and Sussex Healthcare NHS Trust provides emergency and non-emergency services at:

East Surrey Hospital

Redhill
Surrey
RH1 5RH
01737 768511

Surrey and Sussex Healthcare NHS Trust provides non-emergency services at Crawley Hospital which is managed by NHS Property Services.

Crawley Hospital

Crawley
West Sussex
RH11 7DH
01293 600300

We also provide a number of services at four community sites:

Caterham Dene Hospital

Church Road
Caterham
Surrey CR3 5RA
01883 837500

Horsham Hospital

Hurst Road
Horsham



West Sussex RH12 2DR
01403 227000

Oxted Health Centre

10 Gresham Road
Oxted
RH8 0BQ
01883 734000

The Earlswood Centre

Royal Earlswood Park
1 Anderson Court
Redhill
Surrey
RH1 6TP
01737 768511

Need help or advice?

The Patient Advice and Liaison Service (PALS) focuses on improving services for NHS patients. It aims to:

- advise and support patients, their families and carers
- provide information on NHS services
- listen to concerns, suggestions or queries from our patients and the people we care for help sort out problems quickly on their behalf

Contact PALS:

- 01737 768511 x1958 (for all sites)
- pals@SASH.nhs.uk
- PALS, East Surrey Hospital, Redhill, Surrey, RH1 5RH

You can ask a member of staff to contact PALS on your behalf

This information is available in other languages and formats including audio tape, large print and braille. For further information please contact PALS (Patient Advisory Liaison Service) on 01737 231958 or email: enquiries@SASH.nhs.uk



Finances

Our finances

The year in context

The Trust ended 2017-18 with a surplus of £13.6m. This is a notable achievement, allowing the Trust to invest in additional capital works during the year and improving its previously poor liquidity position.

In summary, the Trust:

- ✓ Has delivered a surplus for the second consecutive year
- ✓ Achieved £6.2m of savings (meeting its planned savings target)
- ✓ Received non-recurrent income of £8.2m from Sustainability and Transformation Funding (STF) from NHS Improvement. In conjunction with other non-recurrent items, the underlying position was a £2.6m surplus
- ✓ Stayed within its allocated external financing limit
- ✓ Stayed within its allocated £12.4m capital resource limit
- ✓ Has the lowest cost per weighted activity unit (so unit cost) for any acute trust in England in respect of 2016-17 (national reporting of this data is one year in arrears)

The Trust was not able to achieve the £21.3m surplus financial control total initially assigned to it by NHS Improvement. A revised forecast outturn was agreed with NHS Improvement during the 2017-18 financial year and this was successfully delivered.

The cost per weighted activity unit (WAU) is a unit cost measure introduced as part of Lord Carter and NHS Improvement's Operational Productivity work and recorded in the Model Hospital data portal. The Trust's 2016-17 cost per WAU is the lowest for any acute trust nationally - £2,930 per WAU. Our reference cost index, where 100 is the index level, was 83 – again the lowest in England for an acute trust. These values represent improvement on the last year and describe strong value for money.

This performance is against a context of significant deficits in acute trusts across the country and continued activity pressure nationally and locally. In 2017-18 emergency attendances increased to their highest ever reported levels. Although the Trust's new internal pathways, introduced with the help of commissioners and now including an

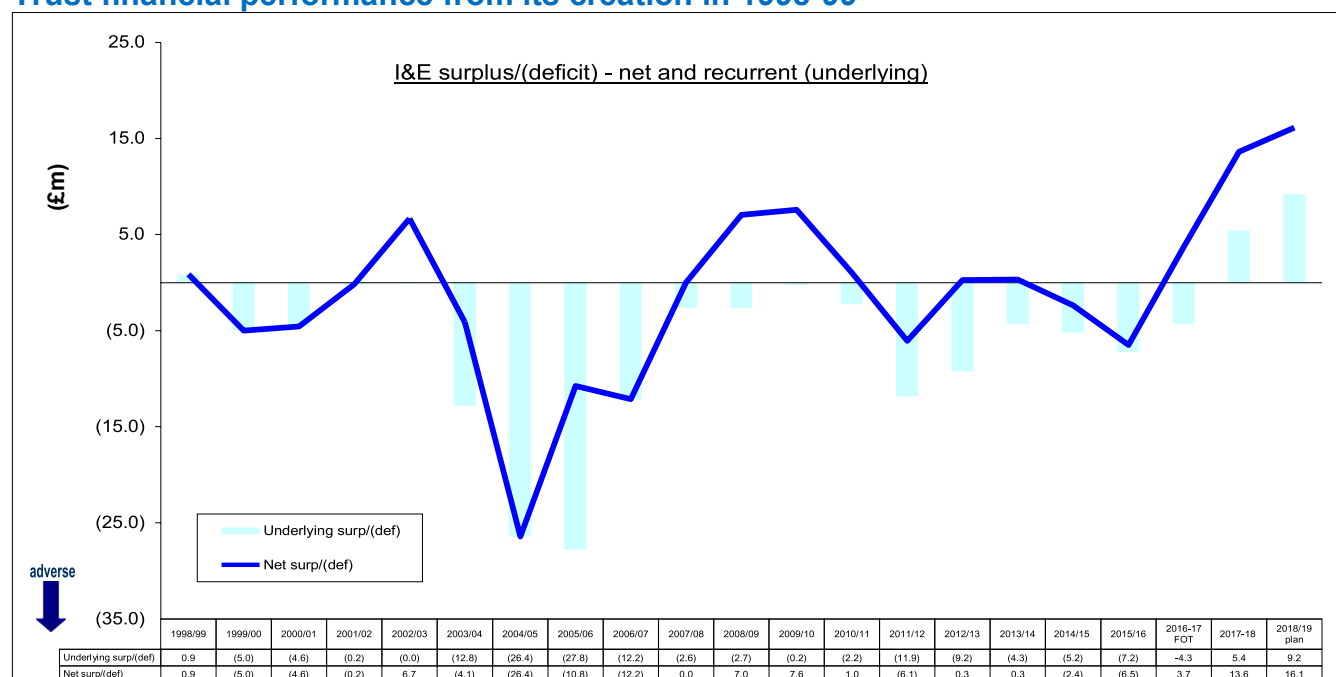
ambulatory care unit, the Kingsfold Unit, which has helped to constrain the number of emergency admissions to Trust beds to manageable levels. The Trust did not have sufficient capacity to treat the expected level of planned care (elective) patients referred to us.

Local Clinical Commissioning Groups (CCGs), who pay the Trust the majority of its income for patient care, have recently reorganised themselves and formed the Central Sussex and East Surrey Alliance (CSESA). CSESA and the Trust have both been working more closely together during 2017-18 and that has led to the agreement of an end year financial settlement that provides certainty for both sides, as well as helping in clearing debts in respect of past years.

Within that settlement CCGs have provided a one-off payment that partially covers the impact of the full cost of emergency admissions; there is a 'marginal rate emergency tariff' which otherwise reduces the payment to 70% for numbers of patients above 2008 levels.

Income and expenditure performance is described in the chart below, which provides a view back to the creation of the Trust in 1998-99. The substantial surplus planned for 2018-19 (to meet the control total assigned to the Trust by NHS Improvement) includes non-recurrent provider sustainability funding.

Trust financial performance from its creation in 1998-99



The journey to 2017-18 – a brief financial history

As the graph describes, the Trust has experienced dramatically fluctuating financial fortunes. We went into deficit very soon after the Trust's creation from the merger of the hospitals in East Surrey and Crawley) and after a deceptive respite in 2002-03 the Trust went into a very serious financial decline.

At the peak of those problems, in early 2006, the Trust was placed in formal turnaround by the Department of Health and in 2007 had to borrow £56m to cover the deficits. This initiated significant structural change, notably the divestment of Crawley Hospital to the Primary Care Trust and the transfer in-house of what was the Redwood Diagnostic and Treatment Centre previously run by a private company. A more stable management team was created and in September 2007 a major review was completed by Ernst & Young, paving the way for the loan repayment plan implemented in early 2008.

In the period after 2007 the chart describes a fragile, but notable, financial recovery, and the delivery of the loan repayment plan. During this time the local Primary Care Trusts (predecessors of Clinical Commissioning Groups) provided non-recurrent funding to allow the net surpluses and which, in turn, provided the Trust's contribution to its accelerated loan repayments. This allowed the success of being able to repay most of the £56m loan in just three years and in 2008-09 the Trust's categorisation as financially challenged was formally lifted.

However, underlying operational and quality issues had not been dealt with and in 2010-11 they became very visible. The Trust failed to deliver its full savings plan in this year and just at the point when the financial environment become tougher.

There was a management team change in October 2010, when Michael Wilson joined the Trust as interim CEO. The new team prioritised patient safety and performance improvement and the 2011-12 savings plan was set at the lower end of the expected level while the Trust invested heavily in clinical staff. It is this and the tightening of Government spending, seen through the reduced tariff (price) for national tariff income in that year, that contributed most to the Trust's 2012-13 underlying deficit.

In the last few years, financial performance has improved in-line with improvement in the quality of our services, operational performance and our reputation. The Trust's income has increased in line with the increases in patient numbers. As a consequence of these improvements the Trust's reference costs and cost per weighted activity unit have continued to improve.

The last four years, 2014-15 to 2017-18, have seen emergency activity continue to increase above planned levels, noting that the rates of growth differ geographically (there is more growth from Sussex than in Surrey). That means we have to find

temporary capacity to manage the demand, which involves cancelling elective patients, because emergency patients need the beds, or opening “escalation” areas (clinical areas not normally staffed to manage inpatients). These actions are massively inefficient, adding cost and losing income.

The Trust, with its partners in the local health system continues to work jointly to manage the demand for emergency and urgent care.

In 2015-16, we reported how the stronger working with partners in the health system was manifested by the creation of an integrated re-ablement unit operated (and paid for equally) by the Trust, East Surrey CCG and Surrey County Council. That has been operating for two years, which helps patients to leave hospital more quickly, and in 2016-17 was joined by the establishment of the Pendleton Unit, which helps prevent admissions of frail elderly patients. We also have GPs in our A&E department to refer people arriving at the hospital to out of hospital services.

In 2017-18 we rebuilt the Emergency Department to allow the GP service to work better - the programme is called primary care streaming, and also to provide better access to ambulances, which helps them turn-around more quickly and get back on the road. In October 2017 we opened Kingsfold Unit, which is an ambulatory care unit and which has been very successful in reducing the number of admissions to hospital beds by providing better access to out of hospital services, or dealing differently with patients’ requirements.

Internally, we have implemented ways of working to ensure our processes are consistent with best practice (the SAFER care bundle), altered how patients pass through our wards and improved how we work with partners to discharge patients more quickly. In 2017-18, we have appointed a new integrated discharge lead nurse, funded jointly by the Trust, CCGs and West Sussex Council, who coordinates hospital, community care, social care and others to get patients fit to leave out of hospital more quickly.

The emphasis on productivity continues and the SASH+ improvement work in partnership with the Virginia Mason Institute has been live for 2 ½ years of its five year initial timeframe. In the year, the programme has added two new work streams while establishing the Lean For Leaders training programme for staff from across the Trust that will eventually see all senior staff from all disciplines, clinical and non-clinical, being accredited in SASH+ tools and techniques for improvement. To date, over 70 staff have graduated and 200 staff are completing the Lean For Leaders modules.

Working relationships with local CCGs have also helped the Trust in the year, and that is underlined by the financial settlement we reached at year end. Rather than go through a transactional process over some aspects of our

contract, we agreed a year end settlement recognising the level of activity described above but also covering areas of issue between us such as the withholding of payment caused by the marginal rate emergency tariff. That settlement also resolved a couple of issues from past years that we needed to bring to a conclusion.

The 2018-19 financial plans and budget set by the Trust meet this control total of £16.1m surplus and includes receipt of £9.3m of non-recurrent sustainability funding.

Reference costs and cost per weighted activity unit

The 2016-17 NHS reference costs (the most recent) are translated into an index to allow comparison between trusts, where the national average is an index of 100.

The Trust's index score has changed, as described in the table below, with the 2016-17 figure at 83. This describes cost management over a long period as well as the granular reporting of work done, and suggests that we have managed the investment in services without increasing our unit costs. The Trust's reference costs were audited in 2015-16 on behalf of the Department of Health and the Trust was found to be materially compliant in its reference cost processes and calculation.

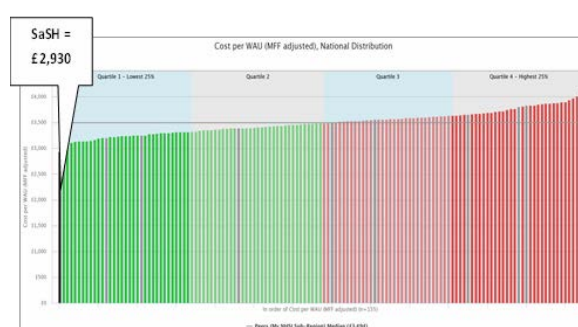
The Lord Carter work on trust operational productivity and efficiency has used the reference cost to create a cost per weighted activity unit measure. This is a value describing the cost to deliver the treatments carried out for patients, as adjusted and weighted for complexity of treatment, which can be compared with the average unit cost across the country. The Trust has a cost per weighted activity unit of £2,930, which is the lowest unit cost in England.

Trust productivity metrics

	Reference cost index	Adjusted treatment cost	Cost per weighted activity unit
2006/07	116		
2007/08	95		
2008/09	86		
2009/10	94		
2010/11	97		
2011/12	89		
2012/13	92		
2013/14	92		
2014/15	88	£0.88	
2015/16	86		£3,010
2016-17	83		£2,930

Model Hospital: Cost per weighted activity unit 2016/17

Distribution of trusts in England



Charts show ranking position for all trusts with data reported in the Model Hospital – colour bandings reflect quartile – darker green (left) is best quartile, darker red (right) worst quartile

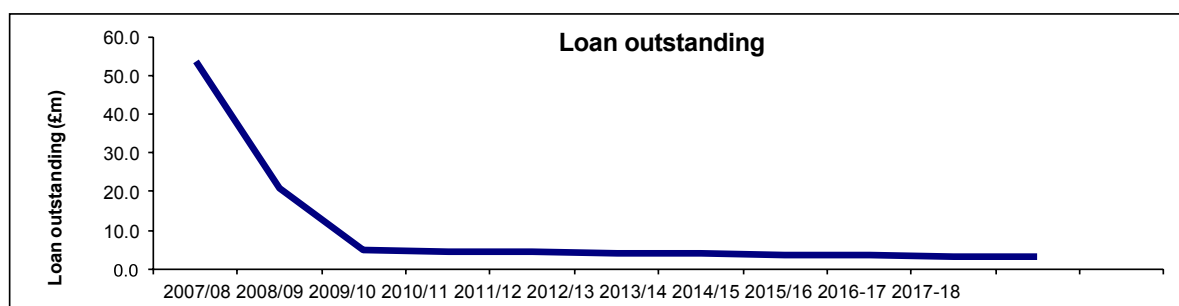
The loan and the statutory breakeven duty

Surrey and Sussex Healthcare NHS Trust secured its £56m working capital loan at the end of 2006-07 to cover debts from its poor financial performance up to that time. At that time, this was the largest loan allowed for any NHS Trust.

The current position on the loan is described below, with only £3m left outstanding. The Trust is now making the scheduled payments required by its 25 year loan agreement against that balance.

Loan repayment schedule

Loan repayment plan	2007/08 (£m)	2008/09 (£m)	2009/10 (£m)	2010/11 (£m)	2011/12 (£m)	2012/13 (£m)	2013/14 (£m)	2014/15 (£m)	2015/16 (£m)	2016-17 (£m)	2017-18 (£m)
Loan outstanding b/fwd	(55.9)	(53.7)	(20.7)	(4.8)	(4.5)	(4.3)	(4.1)	(3.9)	(3.6)	(3.4)	(3.2)
Conversion to PDC		26.0	8.0								
Trust repayment	2.2	7.0	7.9	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Loan carried forward	(53.7)	(20.7)	(4.8)	(4.5)	(4.3)	(4.1)	(3.9)	(3.6)	(3.4)	(3.2)	(3.0)



The loan repayment plan had been acting as a proxy for meeting the statutory breakeven duty, which the Trust has been in breach of since 2007-08. The statutory breakeven duty is set out in Schedule 5 of the NHS Act 2006 and case law states that a surplus of an equal size to any past deficits needs to be accumulated in a period of a maximum of five years after the deficit was recorded. However, as this does not take account of any loan arrangement and the repayment the Trust has achieved, the Trust is still technically in breach.

The external auditors of NHS Trusts have responsibilities under section 30 of the Local Audit and Accountability Act 2014 to report on unlawful matters by issuing a referral to the Secretary of State. Previously, this was described under Section 19 of the Audit Commission Act 1998. The Trust's auditor did so in a Section 19 letter at the start of the 2011-12 financial year and issued another letter, at the request of the Audit Commission, with the 2013-14 financial accounts. As the Trust's breach is a technical one, there is no impact on the Trust, beyond explaining the above and the auditors will not be issuing another letter advising anything further on this matter.

Finally, NHS Improvement have issued new guidance in respect of the break-even duty (April 2018) and the format of reporting has changed in the accounts (at note 52) with the start point being 2009-10. This is because 2009-10 was the first year of International Financial Reporting Standards (IFRS) implementation and NHS Improvement regard that as a more suitable point from which the breakeven duty should now be assessed. Recognising that it would be onerous to change the law in respect of this arcane technicality it is, however, unfortunate that the opportunity has not been taken in this guidance to deal with the anomaly of loans being used to cover the cash shortfall.

Other cash borrowing

As mentioned above, the Trust's cash position improved with its move into surplus, however the Trust still has a working capital facility (rather like an overdraft). At the end of 2017-18 that stands at £12.5m.

In order to manage its cash flow (partly from our historical position, partly from the deficit in 2015-16 and 2014-15 but also because of delays in payments since then) the Trust secured a £19.8m working capital facility during 2015-16. That 'overdraft facility' (this is not a loan like the £56m detailed above) has much reduced but will remain in place as the Trust moves into 2018-19. As the Trust moves further into surplus more of the facility may well be repaid, however it is prudent to maintain the flexibility provided by the facility.

Finally, the Trust has also borrowed cash to support its capital programme (for building works and equipment) over the years. Overall it has borrowed £13.5m since 2010-11 in three separate loans. There is £7.5m left to repay on these loans at 31 March 2018.

Liquidity - working capital and cash

Liquidity has sat resolutely on the Board Assurance Framework as one of our main strategic risks the Trust faces for many years.

The balance sheet was not particularly strong when the Trust was created and the substantial deficits up to 2006-07 drained its working capital to the point where the only way to keep payments going was to take out the £56m loan. Although this was the largest loan allowed for any NHS trust at the time, it did not cover the full extent of the liquidity problem.

In 2011-12 the Trust needed an injection of cash and the fragility of the position exacerbated by financial deficits meant that in 2015-16, the Trust secured the working capital facility.

However, the 2016-17 surplus, and the £13.6m surplus in 2017-18 is helping significantly to resolve the bulk of the Trust's liquidity problem. Delivering the planned £16.1m surplus in 2018-19 will clearly help even further.

As a result, the Trust has reduced the level of risk on the Board Assurance Framework in respect of cash flow and we are looking to be able to rely much less on our working capital facility and, while keeping it current, repaying some of it.

The Trust improved cash position provides a much stronger financial foundation for its on-going investment in the additional capacity it needs to meet the healthcare needs of the population it is proud to serve.

Looking forward – sustainability: financial strategy overview

The Trust's financial strategy is to establish the Trust's long term financial stability through short term and medium term objectives as follows:

Short term:

- stabilising the Trust's clinical services in the face of increasing emergency demand to provide sufficient capacity to deliver clinical and financial plans;
- recover the normalised position of the Trust by 2017-18

Medium term:

- become a financially sustainable organisation through continuous operational efficiency, improving health outcomes and working in fuller and more effective partnership with commissioners, local authorities and other providers
- creating a flexible and commercial organisation able to quickly and effectively respond to all the demands of the changing NHS environment

The financial plan connection to the operational plan

2016-17 saw the delivery of a non- recurrent surplus that has become recurrent as the Trust moved into 2017-18. We have, therefore, achieved the short term objective to recover the normalised position of the Trust.

The financial plan is supported by an operational plan, describing the activity changes that would allow the management of demand and the balancing of non-elective to elective activity. Simplistically, that's about managing emergency demand and maintaining capacity to do elective work.

Additional capacity for elective activity was created in 2015-16 (an additional elective ward and an additional theatre, plus additional day case capacity) but the level of emergency demand prevented its effective use. That problem continued through 2016-17 and into 2017-18 as described above (at the end of the brief financial history section).

This was despite better management of emergency work from the creation of new units and new ways of working. As a result the Trust did not deliver its elective income plan in 2017-18, particularly in the first half of the year. That has also contributed to uncomfortable fluctuation of the delivery of the 18 week referral to treatment standard, and overall we did not achieve the standard for the year.

In October 2017-18 the Kingsfold Unit opened and along with the work around the Emergency Department's Primary Care Streaming has further helped the management of emergency activity. The Surgery Centre at East Surrey Hospital, opened in September 2017, has significantly improved our day case capacity and thus our ability to respond to the growing demand for our services.

That has helped the second half of the year, despite the interruption of winter, show improved performance in elective work and outpatients and helped to deliver the final financial position.

Finally, again, the settlement with CCGs has been a helpful conclusion that has avoided much transactional activity.

2018-19 budgets

The 2018-19 revenue budget has been constructed to facilitate delivery of the £16.1m income and expenditure surplus as required by NHS Improvement.

The control total has been set by NHS Improvement and the Board confirmed its acceptance in the Trust's Plan submission in April 2018.

Part of the reason for the large surplus target is due to the Trust's receipt of significant additional income from the higher prices for tariff activity as a result of the change to HRG4+ in 2017-18, and the surplus will also be supported by additional provider sustainability funding.

The revenue budget includes:

- Receipt of £9.3m provider sustainability funding (PSF)
- The combined core cost improvement plan (CIP) and rollover of full year effects of productivity gain totals £5.7m (1.7% of turnover)
- £2m financial contingency against non-delivery of the above savings and productivity programme
- Expenditure through a quality reserve budgeted at £1m

2018-19 savings and productivity

In addition to the data about the Trust's cost per weighted activity unit referred to above, the Carter programme (NHS Improvement operational productivity) has established a broad range of workstreams with benchmarking and other data set out on a web-based portal called the Model Hospital.

Within the Trust the chief executive now chairs a Model Hospital Group which methodically reviews data from the portal with clinical specialties and administrative departments in the Trust. The outputs provide inputs to the cost improvement plan, productivity plans and clinical improvement plans.

The Trust benchmarks well in the majority of categories, which include nursing; pathology services; medicines management; back office; estates and facilities; procurement and detail Getting It Right First Time programme specialties.

Chart: Model Hospital productivity benchmark

Model Hospital: 5 year Productivity opportunity

National benchmark data

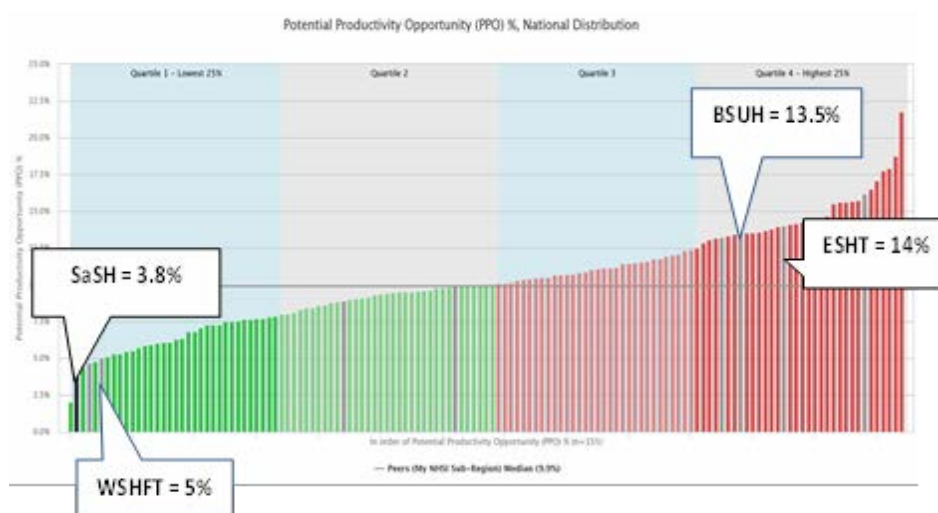


Chart shows ranking position for all trusts with data reported in the Model Hospital – colour bandings reflect quartile – darker green (left) is best quartile, darker red (right) worst quartile

The Model Hospital data shows that the Trust has one of the lowest overall productivity gains to achieve when benchmarked against other English Trusts. This reduces the opportunity for further cost improvements, however the Trust continues to look at what it can do to reduce its costs while maintaining and improving its services. The core cost improvement plan (CIP) is set at £4.8m (1.5% of turnover pre PSF) in line with Model Hospital Indicators and agency reduction.

The rollover of full year effects of productivity gain takes this figure to £5.7m (1.7%) of the same turnover.

Cost improvements are modelled to come from all areas of the Trust but major on agency cost reductions, procurement, usage of consumables (notably connected with GIRFT (Get it right First Time) orthopaedics) and drug expenditure. Efficiencies contributing to the productivity gain flow from outpatient demand and capacity work, reducing length of stay for non-elective patients and theatre efficiency.

Further information on the Trust's approach to improving its productivity and efficiency is set out elsewhere in this Annual Report and summarised above in the brief financial history section, describing our SASH+ programme and other initiatives.

Analysis of financial data

The key financial statements from the 2017-18 accounts are in the appendix. The table below provides a fuller summary of our income and expenditure performance since 2009-10, using the EBITDA* presentation.

Detail of overall income and expenditure performance since 2007-8

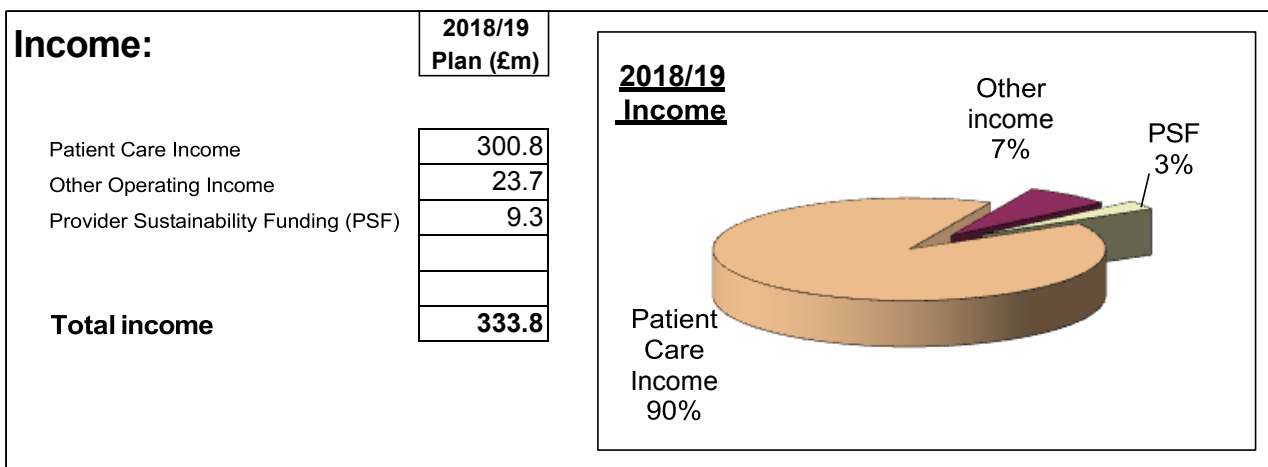
Income & Expenditure:	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016-17	2017-18
	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)
EBITDA presentation											
Income from patient care	153.4	172.1	174.1	179.8	189.3	197.0	210.6	224.8	240.9	258.0	283.9
Other operating income	17.6	15.9	20.8	16.4	20.3	29.0	20.8	19.0	24.0	28.4	31.6
Net operating income	171.0	188.0	194.9	196.2	209.6	226.0	231.4	243.8	264.9	286.3	315.4
Operating expenses	(158.1)	(171.9)	(178.9)	(187.2)	(207.0)	(215.0)	(220.4)	(234.5)	(258.2)	(268.4)	(286.9)
EBITDA (op surplus/(deficit))	12.9	16.1	16.0	9.0	2.6	11.0	11.0	9.3	6.7	17.9	28.5
Net interest and other items	(2.3)	(1.5)	(0.8)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.5)	(1.0)	(0.8)
Depreciation	(5.2)	(5.7)	(4.5)	(4.7)	(5.4)	(7.3)	(7.2)	(7.8)	(8.7)	(9.2)	(9.4)
PDC dividends payable	(1.4)	(1.8)	(2.9)	(3.0)	(3.0)	(3.1)	(3.2)	(3.6)	(3.9)	(4.1)	(4.7)
Impairments/donated assets	(3.9)		(0.2)								
NHS performance surplus/(deficit)	0.0	7.0	7.6	1.0	(6.1)	0.3	0.3	(2.4)	(6.5)	3.7	13.6
Impairments/donated assets				(4.8)	0.0	0.1	0.0	0.0	2.4	(0.2)	0.0
NET SURPLUS/(DEFICIT)	0.0	7.0	7.6	(3.7)	(6.1)	0.4	0.3	(2.4)	(4.1)	3.4	13.6
Underlying surplus/(deficit)	(2.6)	(2.7)	(0.2)	(2.2)	(13.3)	(9.2)	(4.3)	(5.2)	(7.2)	(4.2)	7.9
B*even duty: Cumulative deficit	(54.1)	(47.0)	(39.4)	(38.4)	(44.5)	(44.2)	(43.9)	(46.3)	(52.9)	(49.2)	(35.6)

*EBITDA – earnings before interest, tax, depreciation and amortisation

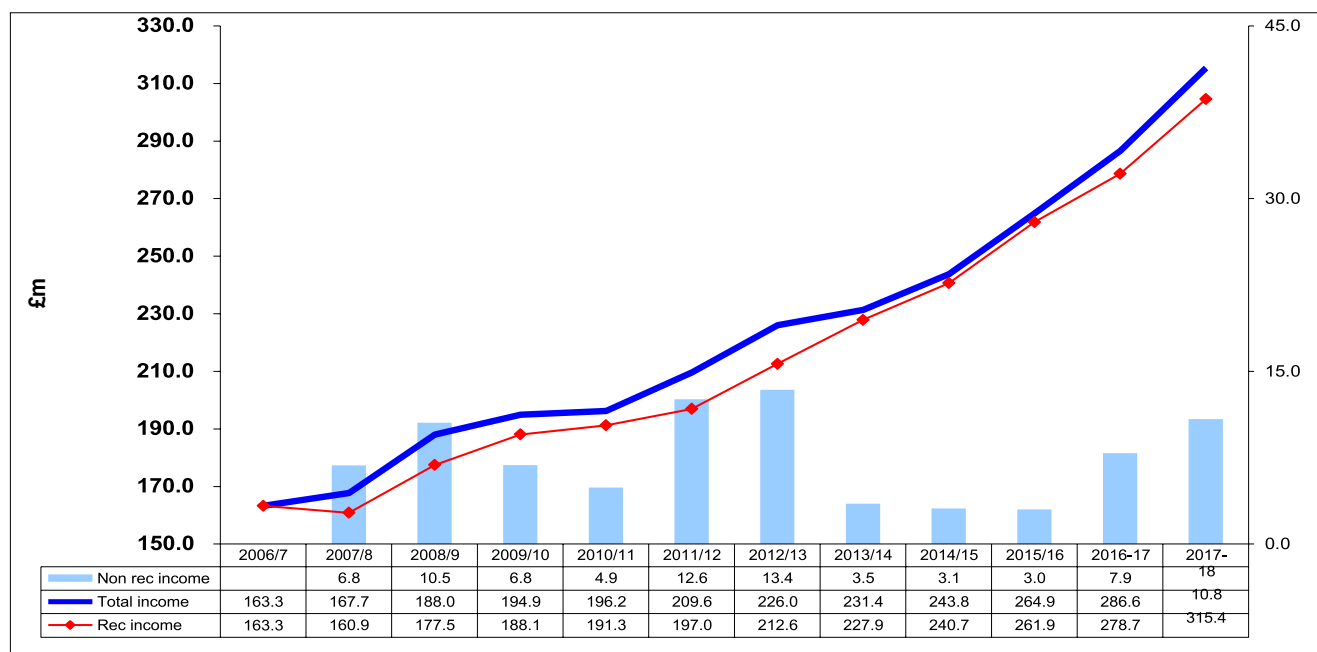
Income 2018-19 – looking forward

In 2018-19 our income is forecast to total £333.8m, taking into account £9.3m of provider sustainability funding.

Trust forecast income 2018-19



Total Trust Income 2006-07 to 2017-18



- a. The transfer of Crawley Hospital and Surrey Hospital Information System (HIS) caused a reduction in income between 2005-6 and 2007-8, with a loss of clinical income from the creation of Walk in Centres in Crawley and Redhill. These reductions were not matched by similarly timed cost reductions until 2007-8 and, as a result, the Trust was in deficit until this point.
- b. 2008-9 saw the largest step change in the Trust's income over this period for two reasons:
 - a. a significant jump in non-elective activity but also the additional activity necessary to meet the 18 week target. The income from this increase was lost at the time to contract challenges by PCTs but then replaced with non- recurrent funding. In summary however, the income increase here is from extra activity, not non-recurrent funding (the non-recurrent funding line has been adjusted).
 - b. 2008-9 was also the last year of the phased introduction of payment by results, where the Trust was a significant gainer - £6.5m was added to the Trust's market forces factor in the year.
- c. 2009-10 saw activity income fully consolidated as contract payment (being paid for what is done, and with some increase) but suppressed by the income agreement that year. The Trust has reached agreements on overall annual Contract income with its local PCTs to settle contractual disputes through overall annual memoranda of understanding (MoUs) in several of the last few

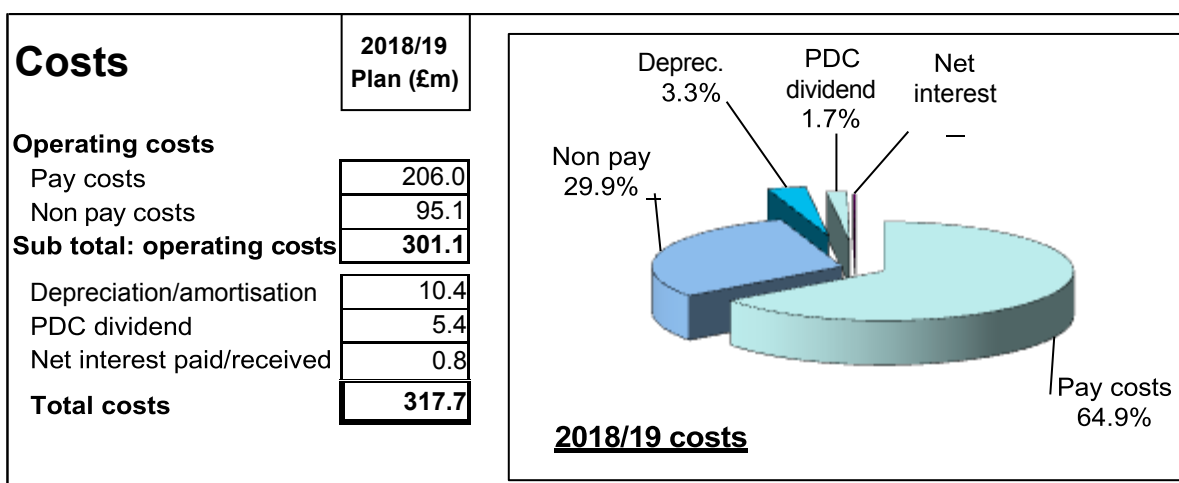
years.

- d. The increase seen in 2010-11 is therefore partly a delay in seeing 2009-10 benefit. There was significant loss of recharge (non-contract) income in 2010-11, contributing to a decline in total income compared to that from activities.
- e. 2011-12 saw a steeper increase in income with increased elective activity to meet 18 weeks, some non-recurrent income for that purpose, the taking back of one of the walk in centres (Redhill UTC) referred to at (a) and continued growth in outpatient income.
- f. 2012-13 shows a continuation of 2011-12, increased productivity and more activity, unfortunately without the reduction in non-electives. The change since 2010-11 is noticeable in the chart.
- g. 2013-14 sees income increasing at a reduced rate with tariff deflation taking effect.
- h. 2014-15 and 2015-16 – the income gradient has got steeper in 2014-15 and again in 2015-16 with increased activity in the hospital (both non-elective and elective) – even after the impact of the marginal rate for emergency tariff reduction and the stated base value deduction for specialised commissioning. Note: 2015-16 and 2016-17 income excludes donated asset benefits.
- i. In 2016-17 income growth has continued at the previous rate, with the additional non-recurrent income making the gradient a little steeper in year.
- j. In 2017-18 total income increased by £29.1m (10.2%) over 2016-17 levels
- k. £25.9m of this increase was patient related income. The remaining increase related to the receipt of Sustainability and Transformation Funding (STF).

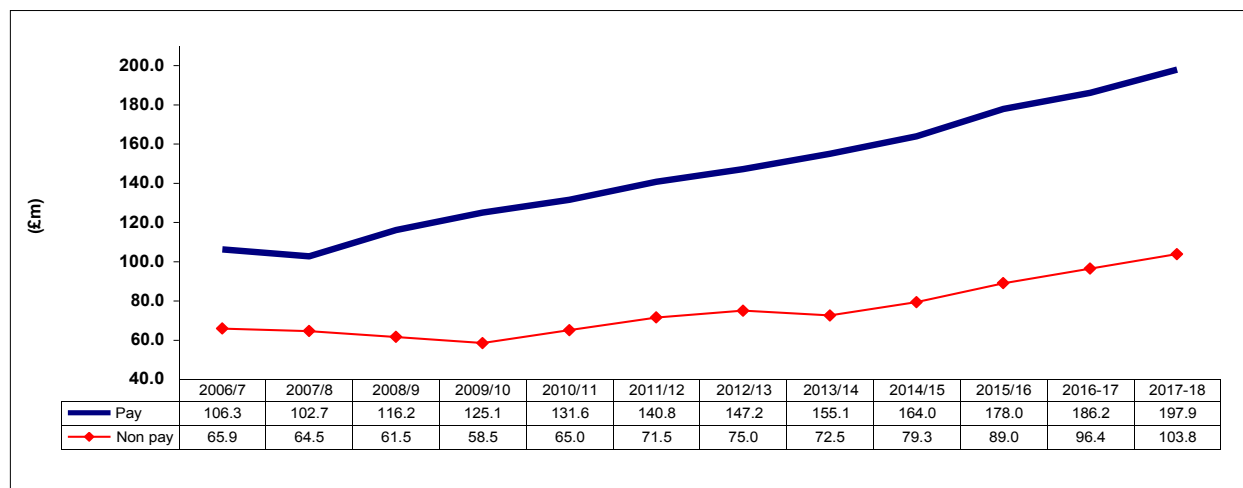
Costs 2018-19 – looking forward

Costs in 2018-19 are forecast to total £317.7m, split as described in the table and chart below.

Trust forecast costs 2018-19



Trust Costs from 2016-17 to 2017-18



- Pay costs fell from 2004-5 to 2007-8 with the loss of Crawley Hospital, the Surrey Hospital Information System (HIS) and other smaller services that were absorbed by other parts of the local NHS.
- Pay costs rose significantly between 2007 and 2008 (where the main hit was taken) as the Trust took back the Redwood Centre, moving a non-pay charge

to pay but also giving a saving in non-pay as the profit element of the charge was lost.

- c. At the same time, activity increased significantly in 2008-9 and three additional wards were opened at this time. In 2009, Surrey Hospital Information System (HIS) broke up, with staff returning. The rise in pay costs from 2007-8 is the main driver behind the Trust's increasing cost base, noting that simultaneously reference costs remained at below average levels.
- d. The increase in 2010-11 non pay is mainly due to the £4.8m non-recurrent impairment.
- e. In 2011-12, there was investment in staff and the increase in outsourcing, which provided an additional (partial) cost because it was on top of the fixed cost of the surgery division. Additionally VAT and CNST increases were substantial in year (£1.6m between them).
- f. 2012-13 and 2013-14 sees an increase in staff costs as activity costs increase and with further investment in clinical priorities (for example midwife numbers, which were increased to match the new target ratio of midwives to births) – it should be noted that the increases in both pay and non-pay costs are not as steep as the increase in income. Non-pay, however, which has been a particular focus for savings, shows a decline in 2013-14.
- g. 2014-15 and 2015-16 see increases in both pay and non-pay to deliver the increased income, with a reduced level of cost improvements/increased level of agency spend in 2015-16. To state the obvious, the cost increase in both years is greater than the income increase – resulting in the reported deficits in both years.
- h. Pay spend growth in 2016-17 is not as steep as in 2015-16 and the gradient of the overall spend lines is shallower than the income chart. Spend was less than income, resulting in the stated surplus.
- i. Total spend increased by £19.1m (6.8%) over 2016-17 spend levels. £11.6m of this was pay related (6.2% increase over 2016-17). Non-pay (including depreciation and finance charges increased by £7.5m (7.7%) over 2016-17

Capital

In 2017-18, the Trust spent £13.5m on capital investment (buildings, IT and equipment, and a finance lease for its bed contract). This figure included £1.1m of capital resource limit from 2016-17 returned to the Trust after we handed back capital resource limit to the Department of Health to support the national NHS financial position in 2016-17.

The Trust structures its programme to ensure that maintenance and refurbishment is completed, that we invest in improving patient areas and support the Trust strategy to ensure patients are treated in a safe, high-quality environment, and which is welcoming and convenient for them and their families. The programme is successfully transforming the estate and has reduced the cost of maintenance as we modernise the hospital.

A wide-range of different projects were delivered in-year, a lot of smaller projects in fact, with the principle focus being investment in estate to improve how the Trust works and improve care for patients, including the following projects:

- Improvements to the Emergency Department (ED) (£1.3m): a new drop-off zone for ambulances with a canopy and changes to how we triage patients inside ED so that GPs can assess more patients and stream them into primary care services. Also, there is now large lettering on a red background that reduces the anonymity of the emergency department;
- The Kingsfold Ambulatory Care Unit (£2.9m): creating a substantial space above the Integrated Reablement Unit with 28 treatment spaces to care for ambulatory (mobile) patients who would otherwise have gone to the Emergency Department for assessment and likely been admitted to a bedded ward. The unit ensures faster assessment and treatment and the care model is intended to direct patients to non-hospital services or return as outpatients quickly, while ensuring that anyone who needs it is admitted to a hospital bed. The unit has been open throughout the winter and has helped the Trust manage the pressures of winter.
- A new Surgery Centre (£1.5m spent in 2017-18): re-providing and improving the capacity for day surgery (planned care without an overnight stay) at the East Surrey Hospital site.

Although the business case and loan were approved by NHS Improvement, funding for the next stage of the enhancement of our electronic patient records system (EPR Digitise) and electronic prescribing and medicines administration was not forthcoming from the Department of Health and Social Care in 2017-18. However we anticipate the £4.6m needed will be made available in 2018-19, and the Trust has requested a larger capital budget (capital resource limit) to allow the use of some of the cash secured from the projected 2018-19 surplus to provide additional hospital capacity.

Apart from EPR, the other headline for 2018-19 capital is the refurbishment and redesign of the neonatal unit, where we don't have enough space for our cots. The final business case for that is expected to be approved in Summer 2018, with a start on site later in the year.

Surrey And Sussex Healthcare NHS Trust

Annual accounts for the year ended 31 March 2018

Independent Auditors' Report to the Directors of Surrey and Sussex Healthcare NHS Trust

Report on the audit of the financial statements

Opinion

In our opinion, Surrey and Sussex Healthcare NHS Trust's financial statements:

- give a true and fair view of the state of Surrey and Sussex Healthcare NHS Trust's affairs as at 31 March 2018 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report, which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income, the Statement of Cashflows, the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of Surrey and Sussex Healthcare NHS Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which ISAs (UK) require us to report to you when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to Surrey and Sussex Healthcare NHS Trust's ability to continue as a going concern.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Statement of Directors' responsibilities set out on page 2, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Reporting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditors' responsibilities 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 auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

Use of this report

This report, including the opinions, has been prepared for and only for the Directors of Surrey and Sussex Healthcare NHS Trust as a body in accordance with the Code of Audit Practice and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other reporting

Opinions on other matters prescribed by the Code of Audit Practice

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the Department of Health and Social Care Group Accounting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of Surrey and Sussex Healthcare NHS Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that Surrey and Sussex Healthcare NHS Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018. We have nothing to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- Information in the Annual Report is:
 - materially inconsistent with the information in the audited financial statements; or

- apparently materially incorrect based on, or materially inconsistent with, our knowledge of Surrey and Sussex Healthcare NHS Trust acquired in the course of performing our audit; or
 - otherwise misleading.
- We have referred a matter to Secretary of State for Health under Section 30 of the Act because we had reason to believe that the Trust, or a director or officer of Surrey and Sussex Healthcare NHS Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- We have issued a report in the public interest under section 24 of the Act.
- We have made written recommendations to Surrey and Sussex Healthcare NHS Trust under section 24 of the Act in the course of, or at the conclusion of the audit.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006.



Anna Blackman (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Southampton

25 May 2018

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....

Michael Wilson CBE
Chief Executive

Date.....25/05/18.....

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

Signed.....

Michael Wilson CBE
Chief Executive

Date.....25/05/18.....

Signed.....

Paul Simpson
Chief Finance Officer

Date.....25/05/18.....

Statement of Comprehensive Income for the Year Ended 31 March 2018

		2017/18	2016/17
	Note	£000	£000
Operating income from patient care activities	3	283,866	257,968
Other operating income	4	31,555	28,367
Operating expenses	6, 8	(296,302)	(277,820)
Operating surplus from continuing operations		19,119	8,515
Finance income	11	26	23
Finance expenses	12	(850)	(977)
PDC dividends payable		(4,686)	(4,098)
Net finance costs		(5,510)	(5,052)
Other losses	13	-	(27)
Surplus for the year from continuing operations		13,609	3,436
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	18	7,897	5,106
Total comprehensive income for the period		21,506	8,542

The Trust's reported NHS financial performance position is derived from its current surplus but adjusted for the treatment of donated assets and impairments.

The primary financial statements on pages 1 to 4 form part of this account.

Statement of Financial Position as at 31 March 2018

		31 March 2018 £000	31 March 2017 £000
	Note		
Non-current assets			
Intangible assets	15	1,784	1,822
Property, plant and equipment	16	181,253	170,185
Trade and other receivables	24	3,982	3,931
Total non-current assets		187,019	175,938
Current assets			
Inventories	23	5,063	4,479
Trade and other receivables	24	24,351	17,504
Cash and cash equivalents	27	5,279	5,575
Total current assets		34,693	27,558
Current liabilities			
Trade and other payables	28	(24,793)	(24,301)
Borrowings	31	(2,085)	(1,848)
Provisions	33	(267)	(304)
Other liabilities	30	(1,916)	(2,524)
Total current liabilities		(29,061)	(28,977)
Total assets less current liabilities		192,651	174,519
Non-current liabilities			
Trade and other payables	28	(3,212)	(3,312)
Borrowings	31	(24,651)	(28,875)
Provisions	33	(1,840)	(1,935)
Total non-current liabilities		(29,703)	(34,122)
Total assets employed		162,948	140,397
Financed by			
Public dividend capital		152,894	151,849
Revaluation reserve		50,548	43,633
Income and expenditure reserve		(40,494)	(55,085)
Total taxpayers' equity		162,948	140,397

The notes on pages 5 to 43 form part of these accounts.

Signature

Name

Michael Wilson CBE

Position

Chief Executive Officer

Date

25/05/18

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	151,849	43,633	(55,085)	140,397
Surplus for the year	-	-	13,609	13,609
Revaluations	-	7,897	-	7,897
Public dividend capital received	1,045	-	-	1,045
Other reserve movements	-	(982)	982	-
Taxpayers' equity at 31 March 2018	152,894	50,548	(40,494)	162,948

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	148,849	39,385	(59,379)	128,855
Taxpayers' equity at 1 April 2016 - restated	148,849	39,385	(59,379)	128,855
Surplus for the year	-	-	3,436	3,436
Other transfers between reserves	-	(858)	858	-
Revaluations	-	5,106	-	5,106
Public dividend capital received	3,000	-	-	3,000
Taxpayers' equity at 31 March 2017	151,849	43,633	(55,085)	140,397

Statement of Cash Flows for the Year Ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus		19,119	8,515
Non-cash income and expense:			
Depreciation and amortisation	6.1	9,441	9,267
Income recognised in respect of capital donations	4	(173)	(39)
(Increase) / decrease in receivables and other assets		(6,899)	2,821
(Increase) / decrease in inventories		(584)	(869)
Increase / (decrease) in payables and other liabilities		526	(5,264)
Increase / (decrease) in provisions		(137)	(265)
Net cash generated from / (used in) operating activities		21,293	14,166
Cash flows from investing activities			
Interest received		26	23
Purchase of intangible assets		(661)	(1,106)
Purchase of property, plant, equipment and investment property		(11,286)	(10,210)
Receipt of cash donations to purchase capital assets		173	39
Net cash generated from / (used in) investing activities		(11,748)	(11,254)
Cash flows from financing activities			
Public dividend capital received		1,045	3,000
Movement on loans from the Department of Health and Social Care		(5,092)	1,968
Capital element of finance lease rental payments		(263)	-
Interest paid on finance lease liabilities		(54)	-
Other interest paid		(821)	(956)
PDC dividend (paid) / refunded		(4,656)	(3,870)
Net cash generated from / (used in) financing activities		(9,841)	142
Increase / (decrease) in cash and cash equivalents		(296)	3,054
Cash and cash equivalents at 1 April - brought forward		5,575	2,521
Cash and cash equivalents at 31 March	27.1	5,279	5,575

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

The Trust made a surplus (after technical adjustments) of £13.6m in 2017/18. The additional positive cashflows associated with this £13.6m surplus will help improve the Trust's working capital balance and reduce the need to request additional working capital loans. It is anticipated the Revolving Working Capital Facility will still be available to the Trust during 2018/19 and 2019/20 and beyond should the Trust require it. The terms of the Trusts Revolving Working Capital Facility (RWCF) are that this does not need to be repaid until April 2020. It is also likely that this facility and the amount borrowed could be extended by NHSi if so requested by the Trust. The £13.6m surplus delivered in 2017/18, and the agreement of the amounts payable by the Trust's 4 main CCG commissioners for 2015/16, 2016/17 and 2017/18 will mean the Trust will have sufficient cash available to fully repay the £12.5m revolving capital in 2018/19. It is the Trust's desire to do this as the amount borrowed attracts an annual interests charge of 3.5%. The Trust is planning in delivering a £16.1m I & E surplus in 2018/19. Even if this is only partly delivered, as was the case in 2017/18, this will lead to creation of additional positive cash inflows to the Trust that will further support its working capital balances.

There are no plans for the dissolution of the Trust or any transfer of its services to another entity and the Trust is continuing with work to identify and refine efficiency savings to help underpin financial balance over the long-term. Finally, management is not aware of any events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern and has an approved financial plan for 2018/19 and 2019/20 which has been agreed with the NHSi. The financial statements have therefore been prepared on a going concern basis.

Note 1.2 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 Trust applies criteria as required by IAS 17 (Leases) in deciding, initially, whether a lease arrangement exists and where this is the case to then determine the lease classification. This includes determining the following outcomes: transfer of risks and rewards associated with ownership of the asset; whether an option to purchase the asset exists; and also the lease term.

This criteria was applied in leasing the franking machines, e-rostering system, Earlswood facility, public internet, beds and also in the building of staff accommodation.

Note 1.2.1 Sources of estimation uncertainty

The agreement of Memorandum of Understandings with the Trust's four main CCG Commissioners has provided certainty as to the amounts payable to the Trust in respect of clinical income for 2015/16, 2016/17 and 2017/18. The income owed by the Trusts other two main Commissioners, NHS England and Croydon CCG have been agreed in respect of prior years. Amounts owed in respect of 2017/18 are based on recorded activity levels @ national and local agreed tariff rates. Activity levels and related income are discussed and reconciled with Trusts commissioners throughout 2017/18 with the aim to reaching consensus as the amounts due to the Trust. This process will carry on after the trusts year end before agreement is reached as the final amount payable to the Trust. The Trust is confident that the basis of income measurement are robust and fully supportable.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Note 1.5 Expenditure on employee benefits**Short-term employee benefits**

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

Pension costs**NHS Pension Scheme**

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation

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

All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost (DRC).

The District Valuer has confirmed that where DRC is used, the modern equivalent asset (MEA) principle has been applied; it being the underlying use for which the asset is being used that determines the valuation treatment.

Valuations are carried out by DVS Property Specialists for the Public Sector and have been undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant Department of Health Group Manual for Accounts (DoH GAM).

The valuations also accord with the requirements of the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation - Global Standards 2017 and the RICS Valuation - Professional Standards UK (January 2014, revised April 2015), commonly known together as the Red Book, including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.14 refers.

Site Valuations are carried out on a quinquennial basis with a full valuation performed in 2017/18.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Freehold land, assets under construction or development, and assets held for sale are not depreciated.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
 - management are committed to a plan to sell the asset
 - an active programme has begun to find a buyer and complete the sale
 - the asset is being actively marketed at a reasonable price
 - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic 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) and Local Improvement Finance Trust (LIFT) transactions

The Trust does not have any PFI transactions

Note 1.7.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	6	55
Plant & machinery	5	15
Transport equipment	5	5
Information technology	5	8
Furniture & fittings	5	7

Finance-leased assets (including land) are depreciated over the shorter of the useful economic 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, and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic 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 the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO).

Note 1.10 Investment properties

The Trust does not hold any investment properties.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO₂ emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO₂ it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO₂ emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO₂ emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial instruments and financial liabilities**Recognition**

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Note 1.14 Leases

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

Note 1.14.1 The Trust as lessee

Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

Note 1.14.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 33 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

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

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

- (i) donated assets (including lottery funded assets),
- (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust has not incurred any corporation tax liability for 2017/18 and 2016/17.

Note 1.20 Foreign exchange

The Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Note 1.21 Third party assets

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

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.23 Gifts

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

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies

No functions have been transferred to the Trust from other NHS bodies or local government bodies during 2017/18 or 2016/17. Nor have there been any transfers of functions from the Trust to other NHS bodies or local government bodies.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The Trust has adopted and applied all appropriate accounting financial standards as prescribed by the DHSC Group Accounting Manual.

Note 1.27 Operating Segments

During 2017-18 the provision of healthcare activities are considered to be the entire activities of the Trust. Revenue from patient care activities accounted for 90% of the Trust's income.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18	2016/17
	£000	£000
Acute services:		
Elective income	47,718	45,446
Non elective income	109,883	90,871
First outpatient income	34,070	35,563
Follow up outpatient income	16,549	15,102
A & E income	15,751	14,070
High cost drugs income from commissioners (excluding pass-through costs)	13,932	13,296
Other NHS clinical income	42,955	39,571
All services		
Private patient income	363	217
Other clinical income	2,645	3,832
Total income from activities	283,866	257,968

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	26,665	28,131
Clinical commissioning groups	248,725	220,482
Other NHS providers	278	347
Non-NHS: private patients	363	217
Non-NHS: overseas patients (chargeable to patient)	552	939
NHS injury scheme	661	652
Non NHS: other	6,622	7,200
Total income from activities	283,866	257,968
Of which:		
Related to continuing operations	283,866	257,968

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

	2017/18	2016/17
	£000	£000
Income recognised this year*	552	939
Cash payments received in-year	207	86
Amounts added to provision for impairment of receivables	404	420
Amounts written off in-year	53	227

*Overseas patient income included within this note (amounting to £552k in 2017/18) only relates to overseas patients who do not come under the UK's reciprocal arrangement for the provision of healthcare. Overseas patients that are covered by the UK's reciprocal arrangement are invoiced to NHS Crawley, and are thus categorised as income from Clinical Commissioning Group income. Income covered by reciprocal arrangements amounted to £393k in 2017/18. So total income received by the Trust in respect of overseas patients amounted to £945k in 2017/18 (being the sum of £552k and £393k). The 2016/17 income from overseas patients includes £223k income from NHS Crawley for patients covered by reciprocal arrangements

	2017/18	2016/17
	£000	£000
Research and development	574	568
Education and training	9,795	9,784
Receipt of capital grants and donations	173	39
Non-patient care services to other bodies	6,440	5,940
Sustainability and transformation fund income	8,213	4,850
Rental revenue from operating leases	46	45
Income in respect of staff costs where accounted on gross basis	1,140	1,892
Other income	5,174	5,249
Total other operating income	31,555	28,367
Of which:		
Related to continuing operations	31,555	28,367

Other income relates mainly to income generation activities and includes car parking income (£1,876k), catering (£849k) pharmacy sales (£403k) and creche services (£511k), as well as other ad-hoc divisional income.

Note 5 Fees and charges

Not relevant for this Trust

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	5,984	4,698
Staff and executive directors costs	196,865	185,339
Remuneration of non-executive directors	81	78
Supplies and services - clinical (excluding drugs costs)	30,672	28,361
Supplies and services - general	5,334	5,135
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,765	21,398
Inventories written down	27	-
Consultancy costs	8	20
Establishment	4,079	3,576
Premises	11,260	10,614
Transport (including patient travel)	441	329
Depreciation on property, plant and equipment	8,641	8,512
Amortisation on intangible assets	800	755
Increase/(decrease) in provision for impairment of receivables	371	336
Increase/(decrease) in other provisions	97	-
Change in provisions discount rate(s)	19	158
Audit fees payable to the external auditor		
audit services- statutory audit	78	72
Internal audit costs	111	148
Clinical negligence	6,984	4,989
Legal fees	383	438
Insurance	221	186
Research and development	558	544
Education and training	924	1,350
Car parking & security	155	106
Hospitality	16	10
Losses, ex gratia & special payments	226	289
Other services	202	362
Other	-	17
Total	296,302	277,820
Of which:		
Related to continuing operations	296,302	277,820

Note 7 Impairment of assets

Not relevant for this Trust

Note 8 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	149,105	140,301
Social security costs	15,380	14,263
Apprenticeship levy	731	-
Employer's contributions to NHS pensions	15,785	15,011
Temporary staff (including agency)	17,656	17,301
Total gross staff costs	198,657	186,876
Recoveries in respect of seconded staff	(712)	(512)
Total staff costs	197,945	186,364
Of which		
Costs capitalised as part of assets	250	149

Note 8.1 Retirements due to ill-health

During 2017/18 there were 2 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £101k (£228k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Pensions Agency

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 10 Operating leases

Note 10.1 Surrey And Sussex Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Surrey And Sussex Healthcare NHS Trust is the lessor.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	46	45
Total	46	45
	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	46	45
- later than one year and not later than five years;	182	179
- later than five years.	729	760
Total	957	984

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	26	23
Total	26	23

Note 12.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	791	913
Finance leases	54	36
Total interest expense	845	949
Unwinding of discount on provisions	5	28
Total finance costs	850	977

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

Not relevant for this Trust

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Losses on disposal of assets	-	(27)
Total gains / (losses) on disposal of assets	-	(27)
Total other gains / (losses)	-	(27)

Note 14 Discontinued operations

There were no discontinued operations in either 2017/18 or 2016/17

Note 15.1 Intangible assets - 2017/18

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	9,155	9,155
Additions	762	762
Gross cost at 31 March 2018	9,917	9,917
Amortisation at 1 April 2017 - brought forward	7,333	7,333
Provided during the year	800	800
Amortisation at 31 March 2018	8,133	8,133
Net book value at 31 March 2018	1,784	1,784
Net book value at 1 April 2017	1,822	1,822

Note 15.2 Intangible assets - 2016/17

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	8,843	8,843
Valuation / gross cost at 1 April 2016 - restated	8,843	8,843
Additions	312	312
Valuation / gross cost at 31 March 2017	9,155	9,155
Amortisation at 1 April 2016 - as previously stated	6,578	6,578
Prior period adjustments	-	-
Amortisation at 1 April 2016 - restated	6,578	6,578
Provided during the year	755	755
Amortisation at 31 March 2017	7,333	7,333
Net book value at 31 March 2017	1,822	1,822
Net book value at 1 April 2016	2,265	2,265

Note 16.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	12,100	138,242	633	48,535	33	16,969	5,152	221,664
Additions	-	7,641	150	3,536	-	1,108	300	12,735
Revaluations	300	3,539	-	-	-	-	-	3,839
Reclassifications	-	511	(511)	-	-	-	-	-
Disposals / derecognition	-	(972)	-	-	-	-	-	(972)
Valuation/gross cost at 31 March 2018	12,400	148,961	272	52,071	33	18,077	5,452	237,266
Accumulated depreciation at 1 April 2017 - brought forward	-	111	-	34,554	33	12,931	3,850	51,479
Provided during the year	-	4,138	-	2,658	-	1,532	313	8,641
Revaluations	-	(4,058)	-	-	-	-	-	(4,058)
Disposals / derecognition	-	(49)	-	-	-	-	-	(49)
Accumulated depreciation at 31 March 2018	-	142	-	37,212	33	14,463	4,163	56,013
Net book value at 31 March 2018	12,400	148,819	272	14,859	-	3,614	1,289	181,253
Net book value at 1 April 2017	12,100	138,131	633	13,981	-	4,038	1,302	170,185

Note 16.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	12,100	129,158	1,773	44,968	33	16,636	4,650	209,318
Additions	-	6,130	545	3,567	-	333	502	11,077
Revaluations	-	1,296	-	-	-	-	-	1,296
Reclassifications	-	1,685	(1,685)	-	-	-	-	-
Disposals / derecognition	-	(27)	-	-	-	-	-	(27)
Valuation/gross cost at 31 March 2017	12,100	138,242	633	48,535	33	16,969	5,152	221,664
Accumulated depreciation at 1 April 2016 - as previously stated	-	-	-	31,908	33	11,318	3,518	46,777
Provided during the year	-	3,921	-	2,646	-	1,613	332	8,512
Revaluations	-	(3,810)	-	-	-	-	-	(3,810)
Accumulated depreciation at 31 March 2017	-	111	-	34,554	33	12,931	3,850	51,479
Net book value at 31 March 2017	12,100	138,131	633	13,981	-	4,038	1,302	170,185
Net book value at 1 April 2016	12,100	129,158	1,773	13,060	-	5,318	1,132	162,541

Note 16.3 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018								
Owned - purchased	12,400	143,624	272	12,107	-	3,542	1,277	173,222
Finance leased	-	1,328	-	2,141	-	10	-	3,479
Owned - donated	-	3,867	-	611	-	62	12	4,552
NBV total at 31 March 2018	12,400	148,819	272	14,859	-	3,614	1,289	181,253

Note 16.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017								
Owned - purchased	12,100	131,931	633	13,280	-	3,984	1,287	163,215
Finance leased	-	2,307	-	84	-	-	-	2,391
Owned - donated	-	3,893	-	617	-	54	15	4,579
NBV total at 31 March 2017	12,100	138,131	633	13,981	-	4,038	1,302	170,185

Note 17 Donations of property, plant and equipment

Donations for plant and machinery and IT were received by the Trust primarily from The Friends of East Surrey Hospital.

Note 18 Revaluations of property, plant and equipment

A full revaluation of the Trust site was carried out as at 31 March 2018 by DVS Property Specialists for the Public Sector, RICS qualified. The 2017/18 valuation was prepared by the District Valuer following a site visit. The basis of valuation required from 1st April 2015 is Current Value in existing use, as defined in DoH GAM and reflecting the adaptation approved by FRAB to IAS 16. Current Value has regard to the service potential that an asset provides in support of the Trust's service delivery. The measurement approaches used to arrive at the Current Value of in use assets are for non-specialised operational assets Existing Use Value (EUV) as defined at UKVS 1.3, and for specialised operational assets Depreciated Replacement Cost (DRC) in accordance with UKVS 1.15 and UKGN 2.

The DV confirmed that where depreciated replacement cost (DRC) is used, the modern equivalent asset (MEA) principle has been applied.

The book value of other assets is deemed to be at fair value.

Information technology equipment, plant and machinery, and also furniture and fittings are depreciated on current cost basis evenly over the estimated asset life. The useful economic life for equipment assets is deemed as below:

Intangible Assets (Up to 5 years)

Furniture and Fittings (Up to 7 years)

Information Technology (Up to 8 years)

Transport Equipment (Up to 5 years)

Plant & Equipment (Up to 15 years)

Asset lives of buildings are up to a maximum of 55 years.

Land is not depreciated as it is deemed to have infinite life.

Remaining asset lives are reviewed annually based on high value and short lived assets.

Upward revaluation arising from the revaluation of the buildings has been taken to the revaluation reserve.

Note 19.1 Investment Property

Not relevant for this Trust

Note 20 Investments in associates and joint ventures

Not relevant for this Trust

Note 21 Other investments / financial assets (non-current)

Not relevant for this Trust

Note 22 Disclosure of interests in other entities

The Trust had no interests in other entities in either 2017/18 or 2016/17

Note 23 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	881	724
Consumables	4,182	3,755
Total inventories	5,063	4,479
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £31,206k (2016/17: £29,587k). Write-down of inventories recognised as expenses for the year were £27k (2016/17: £0k).

No inventories have been pledged as security for liabilities in either 2017/18 or 2016/17.

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	17,915	9,713
Accrued income	5,920	7,635
Provision for impaired receivables	(2,119)	(1,748)
Prepayments (non-PFI)	1,454	1,066
PDC dividend receivable	-	1
VAT receivable	752	543
Other receivables	429	294
Total current trade and other receivables	24,351	17,504
Non-current		
Deposits and advances	11	-
Prepayments (non-PFI)	99	59
Other receivables	-	-
Total non-current trade and other receivables	3,982	3,931
Of which receivables from NHS and DHSC group bodies:		
Current	17,694	12,766
Non-current	-	-

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	1,748	1,657
Increase in provision	730	594
Amounts utilised	-	(245)
Unused amounts reversed	(359)	(258)
At 31 March	2,119	1,748

The provision for bad debts is based on the age and probability of recovering specific invoiced debt.

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
	£000	£000	£000	£000
Ageing of impaired financial assets				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	-	-	-	-
Total	-	-	-	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	943	-	1,404	-
90- 180 days	234	-	253	-
Over 180 days	789	-	450	-
Total	1,966	-	2,107	-

Note 25 Other assets

Not relevant for this Trust

Note 26.1 Liabilities in disposal groups

Not relevant for this Trust

Note 27.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	5,575	2,521
Transfers by absorption	-	-
Net change in year	(296)	3,054
At 31 March	5,279	5,575
Broken down into:		
Cash at commercial banks and in hand	5	34
Cash with the Government Banking Service	5,274	5,541
Total cash and cash equivalents as in SoFP	5,279	5,575
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	5,279	5,575

Note 27.2 Third party assets held by the trust

The Trust does not hold any third party assets

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	8,056	8,838
Capital payables	2,333	3,100
Accruals	10,198	8,752
Social security costs	2,106	1,915
Other taxes payable	1,775	1,587
PDC dividend payable	29	-
Accrued interest on loans	27	31
Other payables	269	78
Total current trade and other payables	24,793	24,301
Non-current		
Other payables	3,212	3,312
Total non-current trade and other payables	3,212	3,312
Of which payables from NHS and DHSC group bodies:		
Current	3,010	3,384
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-
- outstanding pension contributions	-	-	-	-

Note 29 Other financial liabilities

The Trust does not have any other financial liabilities

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,916	2,524
Total other current liabilities	1,916	2,524
Non-current		
Total other non-current liabilities	-	-

Note 31 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	1,562	1,562
Obligations under finance leases	523	286
Total current borrowings	2,085	1,848
Non-current		
Loans from the Department of Health and Social Care	21,505	26,597
Obligations under finance leases	3,146	2,278
Total non-current borrowings	24,651	28,875

Note 32 Finance leases

Note 32.1 Surrey And Sussex Healthcare NHS Trust as a lessor

	31 March 2018 £000	31 March 2017 £000
Gross lease receivables	3,872	3,872
of which those receivable:		
- later than five years.	3,872	3,872
Net lease receivables	3,872	3,872
of which those receivable:		
- later than five years.	3,872	3,872

Note 32.2 Surrey And Sussex Healthcare NHS Trust as a lessee

Obligations under finance leases where Surrey And Sussex Healthcare NHS Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	3,669	2,564
of which liabilities are due:		
- not later than one year;	523	286
- later than one year and not later than five years;	1,849	1,144
- later than five years.	1,297	1,134
Net lease liabilities	3,669	2,564
of which payable:		
- not later than one year;	523	286
- later than one year and not later than five years;	1,849	1,144
- later than five years.	1,297	1,134

Total of future minimum sublease payments to be received at the reporting date

- -

Lease liabilities are analysed as following Net Present Value of future contractual payments

	31 March 2018 £000	31 March 2017 £000
Bed Hire Contract (7 year contract from Nov 2017 to Oct 2024)	2,024	-
Earlswood Health Centre Lease (leased until 2030)	1,361	1,420
Oxted Health Centre & Caterham Dene Hospital (costs of occupancy recharged by NHS Property Services based on % of total area occupied. Contracts specifies 6 month notice is required for any change in occupancy requirements).		890
Trust's Public Internet (leased until March 2022)	79	
E-Rostering System (leased until March 2020)	101	148
Franking machines (various machines leased until 2024)	104	106
	3,669	2,564

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	2,112	85	42	2,239
Change in the discount rate	19	-	-	19
Arising during the year	87	33	13	133
Utilised during the year	(174)	(37)	(42)	(253)
Reversed unused	(36)	-	-	(36)
Unwinding of discount	5	-	-	5
At 31 March 2018	2,013	81	13	2,107
Expected timing of cash flows:				
- not later than one year;	173	81	13	267
- later than one year and not later than five years;	692	-	-	692
- later than five years.	1,148	-	-	1,148
Total	2,013	81	13	2,107

Early Departure costs includes early retirements and injury benefits payable to former staff. Pension provisions have been calculated using figures provided by the NHS Pensions Agency, they assume certain life expectancies. Whilst this provides a degree of uncertainty in respect of both timing and total amounts, these estimates are based upon best available actuarial information.

Legal claims are claims brought against the Trust by third parties. An annual adjustment is made to this provision based on the value of the member provision at the year end provided by the NHS Resolution.

Other provisions is amounts relating to on-going Tribunal claims.

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £119,505k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Surrey And Sussex Healthcare NHS Trust (31 March 2017: £78,523k).

Note 34 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
Other	(35)	(67)
Gross value of contingent liabilities	<u>(35)</u>	<u>(67)</u>
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	<u>(35)</u>	<u>(67)</u>
Net value of contingent assets	-	-

Note 35 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	216	3,441
Intangible assets	18	-
Total	<u>234</u>	<u>3,441</u>

Note 36 Other financial commitments

The Trust does not have any other financial commitments

Note 37 Defined benefit pension schemes

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

Not relevant for this Trust

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

Not relevant for this Trust

Note 40 Financial instruments

Note 40.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 40.2 Carrying values of financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available- for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	21,921	-	-	-	21,921
Cash and cash equivalents at bank and in hand	5,279	-	-	-	5,279
Total at 31 March 2018	27,200	-	-	-	27,200

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available- for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	21,422	-	-	-	21,422
Cash and cash equivalents at bank and in hand	5,575	-	-	-	5,575
Total at 31 March 2017	26,997	-	-	-	26,997

Note 40.3 Carrying value of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	23,067	-	23,067
Obligations under finance leases	3,669	-	3,669
Trade and other payables excluding non financial liabilities	20,463	-	20,463
Total at 31 March 2018	47,199	-	47,199

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	28,159	-	28,159
Obligations under finance leases	2,564	-	2,564
Trade and other payables excluding non financial liabilities	26,623	-	26,623
Total at 31 March 2017	57,346	-	57,346

Note 40.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 40.5 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	22,545	28,471
In more than one year but not more than two years	2,075	19,727
In more than two years but not more than five years	6,022	5,545
In more than five years	16,557	3,603
Total	47,199	57,346

Note 41 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	19	51	40	14
Fruitless payments	9	1	7	0
Bad debts and claims abandoned	41	53	77	232
Stores losses and damage to property	16	69	15	38
Total losses	85	174	139	285
Special payments				
Compensation under court order or legally binding arbitration award	14	86	10	23
Ex-gratia payments	14	13	14	4
Total special payments	28	99	24	27
Total losses and special payments	113	273	163	312
Compensation payments received		-		-

Note 42 Gifts

There were no gifts made by the Trust during the reporting period.

Note 43 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Surrey and Sussex Healthcare NHS Trust.

The Department of Health is the parent department for Surrey and Sussex Healthcare NHS Trust and is therefore a related party. During the year Surrey and Sussex Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is also regarded as the parent Department as detailed below:

Crawley CCG
East Surrey CCG
Horsham & Mid Sussex CCG
Surrey Downs CCG
NHS England
Sussex Community NHS Trust
Royal Surrey County NHS Foundation Trust
NHS Resolution
NHS Business Service Authority
Health Education England
NHS Property Services

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies as detailed below:

HM Revenue & Customs
Surrey County Council
Reigate & Banstead Borough Council

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board. The Trust received £166k from the League of Friends in 2017-18.

Note 44 Transfers by absorption

Not relevant for this Trust

Note 45 Prior period adjustments

Not relevant for this Trust

Note 46 Events after the reporting date

Not relevant for this Trust

Note 47 Final period of operation as a Trust of NHS healthcare

Not relevant for this Trust

Note 48 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	81,723	105,638	77,291	103,034
Total non-NHS trade invoices paid within target	62,768	82,440	63,831	84,287
	<u>76.81%</u>	<u>78.04%</u>	<u>82.59%</u>	<u>81.81%</u>
NHS Payables				
Total NHS trade invoices paid in the year	2,391	15,664	2,947	12,661
Total NHS trade invoices paid within target	2,091	14,622	2,436	11,158
Percentage of NHS trade invoices paid within target	<u>87.45%</u>	<u>93.35%</u>	<u>82.66%</u>	<u>88.13%</u>

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

Note 49 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	(4,014)	1,914
External financing requirement	<u>(4,014)</u>	<u>1,914</u>
External financing limit (EFL)	(650)	1,914
Under / (over) spend against EFL	<u>3,364</u>	<u>-</u>

Note 50 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	13,497	11,389
Less: Disposals	(923)	(27)
Less: Donated and granted capital additions	(173)	(39)
Charge against Capital Resource Limit	<u>12,401</u>	<u>11,323</u>
Capital Resource Limit	12,401	11,323
Under / (over) spend against CRL	<u>-</u>	<u>-</u>

Note 51 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	<u>13,641</u>
Breakeven duty financial performance surplus / (deficit)	<u>13,641</u>

Note 52 Breakeven duty rolling assessment

	2008/09	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		7,755	875	(6,056)	254	298	(2,374)	(6,531)	3,672	13,641
Breakeven duty cumulative position	(47,098)	(39,343)	(38,468)	(44,524)	(44,270)	(43,972)	(46,346)	(52,877)	(49,205)	(35,564)
Operating income		194,896	196,030	209,582	226,016	231,702	244,007	264,879	286,335	315,421
Cumulative breakeven position as a percentage of operating income		-20.19%	-19.62%	-21.24%	-19.59%	-18.98%	-18.99%	-19.96%	-17.18%	-11.28%

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.