NHS
Surrey and Sussex Healthcare
NHS Trust

Annual report
2018-19

Putting people first
Delivering excellent, accessible healthcare

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Karen Beadle, senior library assistant

Performance report

Welcome to the Surrey and Sussex Healthcare NHS Trust Annual Report 2018-19, where you can find out more about our plans, our performance and our achievements. We are also happy to have this opportunity to reflect on the positive difference our people continue to make to our patients.

Foreword

Dr Richard Shaw
Chair

Michael Wilson CBE
Chief executive

During the past eight years SASH has been on an incredible improvement journey and we were absolutely thrilled that the accumulation of all of this hard work was recognised last year when we were rated Outstanding by the Care Quality Commission, the highest rating given by the independent health regulator.

This rating is due to the commitment of everyone at SASH to making patient care the best it can be, and the impact of continued improvement through the SASH+ work we do, supported by our partnership with the Virginia Mason Institute. This partnership has helped move SASH from a very difficult place to being an Outstanding organisation. However, we do acknowledge that to remain an Outstanding organisation we must always learn and challenge ourselves and continue to make incremental improvements to the way we work and the care we provide. Through this annual report we are pleased to be able to share some of the highlights of the last year.

In January 2019 the Trust was also rated “Outstanding” for Use of Resources by NHS Improvement and the CQC, in addition to being rated “Outstanding” in respect of Quality.

SASH also delivered a financial surplus for the third consecutive financial year, meeting its planned savings target. In the current climate this is a notable achievement, allowing the Trust to invest in additional capital works during the year and to significantly improve its working capital position.

Mili Doshi, consultant in special care dentistry was awarded a MBE (Member of the Order of the British Empire) for services to dentistry in The Queen’s Birthday Honours. This recognition comes after 17 years of service to the NHS as a dentist and over ten years as a specialist dentist in special care dentistry. As a consultant in special care dentistry Mili cares for vulnerable patients including those with dementia and severe learning difficulties as well as people with severe medical conditions. More recently, at SASH, Mili initiated and led the introduction of Mouth Care Matters, a Health Education England Kent, Surrey and Sussex training initiative to improve the oral health of hospitalised adult patients. Following a successful pilot at East Surrey Hospital, in 2016-17 Mouth Care Matters was rolled out to 12 NHS trusts in Surrey, Sussex and Kent.

Richard Burford, chairman of the Friends’ of East Surrey Hospital was awarded a BEM (British Empire Medal) in the New Year Honours for services to veterans and the community in Surrey. This recognition comes after many years volunteering that, as well as some 14 years as chairman for the Friends’ of East Surrey

Foreword

Hospital, has included 28 years as chairman for the Federation of Old Comrades Association; 25 years for SSAFA, The Armed Forces Charity, the oldest military charity, alongside 23 years with The Honourable Artillery Company, formerly known as the Territorial Army, where he rose through the ranks to become Colonel.

In March 2019, SASH Charity welcomed guests to the opening of our dementia friendly garden, Camomile Courtyard at East Surrey Hospital. The garden was opened by special guest Dame Judi Dench and is a purpose-built garden area for patients living with dementia that provides an alternative space to the hospital wards in a safe outdoor environment with impressive outdoor features, such as; nature areas, stimulating sounds and colours and areas of reminiscence, walls of recall to help evoke memories and conversations among patients living with dementia.

We believe that our success is attributable to all our fantastic staff and to having a clear improvement methodology that really encourages them to make the improvements themselves.

Looking forward into the next year, we will continue to build on our success and to develop the hospital; with the new neonatal unit build and development of our dental unit and women's' outpatients.
We want to thank all of our SASH people, clinicians, staff and volunteers because we know that every achievement and success is only made possible by their hard work, commitment and compassion.

Thank you.

Richard Shaw
Chair

Michael Wilson CBE
Chief executive

Godstone Ward team

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.

Population of 535,000

4,453 staff

735 beds

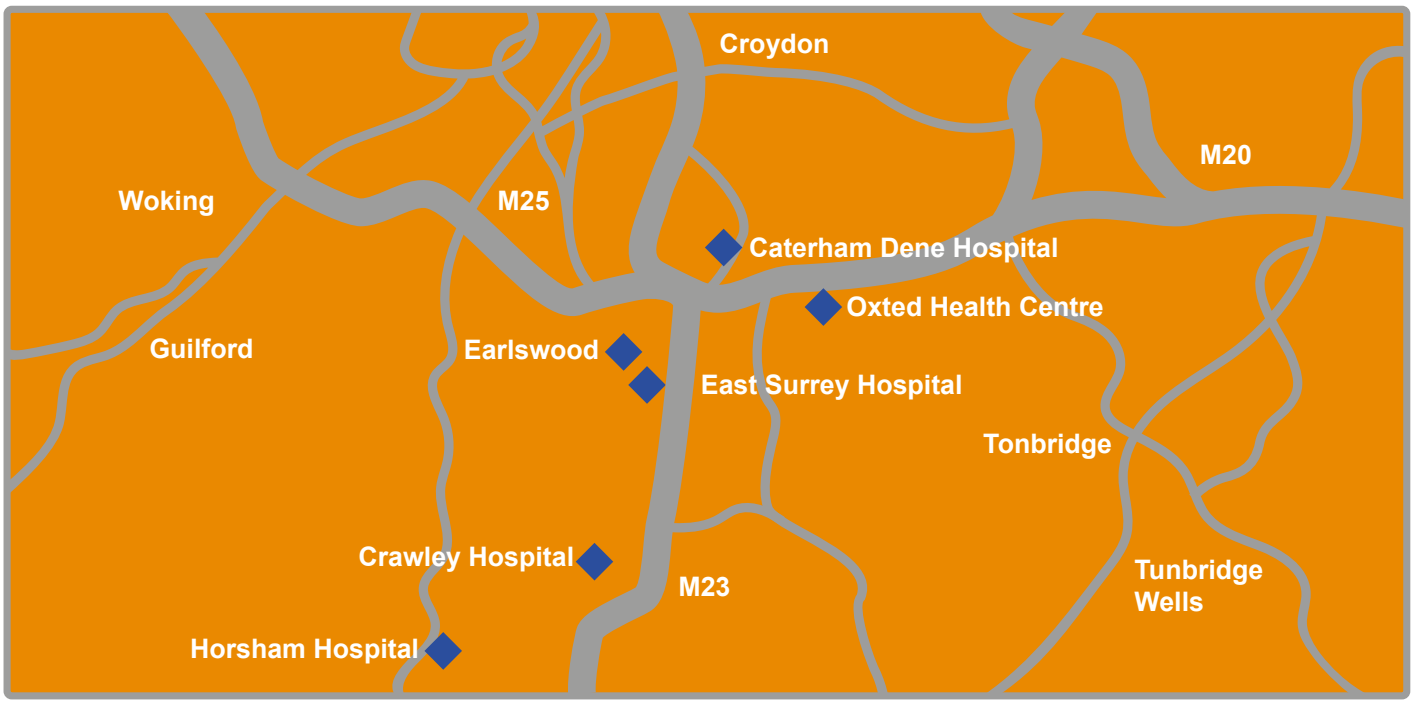
14 operating theatres

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

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 735 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 4,453 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.



Overview - About us

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.

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.

Our clinical commissioning groups (CCGs)

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

In 2018-19, we held contracts with 11 CCGs; of which our co-ordinating commissioner is NHS Horsham and Mid Sussex 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 Musculoskeletal (MSK) which is a partnership hosted by a limited company. The majority of our services are commissioned by:

NHS East Surrey CCG: has 17 GP practices covering the districts of Tandridge, Redhill, Reigate and Horley with a population of 185,000 people

NHS Crawley CCG: has 12 GP practices covering the Crawley district with a population of over 120,000 people

NHS Surrey Downs CCG: has 31 GP practices serving a population of over 305,000 people living in Mole Valley, Epsom and Ewell, Banstead and east Elmbridge

NHS Horsham and Mid Sussex CCG: has 23 GP practices covering the northern part of Horsham District and Mid Sussex District with a population of nearly 240,000 people

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	
Chief	Dr Tony Newman-Saunders (Dr Edward Cetti until 11 March 2019)
Associate director	Jane Griffiths (Alison James from 29 October 2018)
Divisional chief nurse	Victoria Daley (Deputy chief nurse)

Overview - About us

Medicine	
Chief	Dr Ben Mearns
Associate director	Cynthia Quainoo (Alison James until 28 October 2018)
Divisional chief nurse	Nicola Shopland

Surgery	
Chief	Mr Ian Maheswaran (Dr Barbara Bray until 3 May 2018)
Associate director	Natasha Hare
Divisional chief nurse	Jamie Moore

Women and children	
Chief	Miss Karen Jermy (Ms Zara Nadim (until 30 November 2018)
Associate director	Bill Kilvington
Divisional chief nurse	Michelle Cudjoe (Head of midwifery)

Key strategic and cross divisional themes are also led by Clinical Chiefs

Chief Informatics Officer
Dr Tony Newman Sanders, also chief of cancer and diagnostics
Chief of Education
Dr Sarah Rafferty
Chief of Innovation
Dr Des Holden from Jan 2019

Mr Ian Maheswaren, chief of surgery

Our CQC rating

SASH rated outstanding 18 January 2019

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good Oct 2018	Good Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
East Surrey Hospital	Good →← Oct 2018	Good →← Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018
Crawley Hospital	Good →← May 2014	Good →← May 2014	Good May 2014	Good May 2014	Good →← May 2014	Good →← May 2014
Overall trust	Good →← Oct 2018	Good →← Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018

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

SASH is one of the eight non-specialist acute trusts in England to be rated Outstanding.

The CQC report highlighted the success of SASH+ and the positive impact this is having on the people we care for.

> **"We observed many staff in different roles interact with patients in a kind, respectful and considerate way."**
>
> CQC inspector 2018

Our CQC rating

Announcement to staff of CQC rating

Media coverage after CQC announcement

Our CQC rating

> "Unmistakeable evidence of sustained improvement."
>
> CQC inspector 2018

The CQC outlined in their report that our rating had improved to outstanding because:

- Patient safety and the patient experience were the dominant thread running through the Trust strategy and service delivery.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- There was an exceptional culture of data-driven continuous improvement and transformation at the Trust, and this was supported by a comprehensive meeting structure and detailed performance reporting processes. The Trust's risk management policy, processes and tools were well designed.
- The CQC saw unmistakable evidence of sustained improvement achieved through investment in new facilities and increased capacity that resulted in enhanced effectiveness and responsiveness. This was due to a firmly-embedded and positive culture of openness and transparency, supported by a skilled, stable leadership and clear systems of control and governance.

> "Staff involved patients and those close to them in decisions about their care and treatment."
>
> CQC inspector 2018

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The Trust facilities and premises were accessible to patients and clearly signposted. Where there were limitations on space within waiting areas staff acted to mitigate risk and the Trust was working to improve the environment. Signposting within the hospital had improved since the previous inspection.
- The Trust provided care and treatment in accordance with evidence-based guidance. Evidence-based systems were used for treating very sick patients. Staff were aware of clinical guidance for patients with specific needs or diseases.
- Staff provided care and treatment based on national guidance. Speciality clinics operating within the outpatient department followed relevant national guidance and participated in national and local audits.
- Care was delivered by staff that were competent, trained and supported by their managers, to provide safe and effective care. The service provided regular training and development opportunities for staff. There were established developmental career pathways for different roles.
- Patients were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who were close to them and stakeholders was positive about the way staff treated people.
- Staff felt confident they could raise

Our CQC rating

concerns and report incidents, which were regularly reviewed to aid learning. Lessons learned were effectively shared and we saw changes implemented within the wards as the result of investigations.

- Staff at all levels clearly and passionately described how they met patients' needs and demonstrated a good awareness of protected characteristics including race, sexuality, and disability. Staff were well supported by the mental health liaison team and the frailty and interface team.
- The way the Trust supported and encouraged innovation was a real strength.
- The Trust overall score for the National NHS Staff Survey was in the top 20% for the three years preceding the inspection. In some scores this ranked in the top four organisations nationally.
- The Trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

CQC also gave 14 recommendations around areas the Trust should consider for further improvement.

In Urgent and Emergency Care: The Trust should consider:

- all staff are aware of the Trust policy for monitoring patients who have received rapid tranquilisation.
- all staff are aware of the Trust policy for the storage of that prescription pads.
- staff are aware of the Trust policy for the safe storage of Substances Hazardous to Health regulations 2002.
- introducing an audit process to monitor patient records and risk assessments during the transition to between systems.
- how to provide consultant presence 16 hours a day at weekends in line with the Royal College of Emergency Medicine's recommendations.

Medicine:

- a review of mandatory training compliance.

Surgery:

- ambient temperature monitors are introduced in clinic rooms should be monitored and recorded.
- whether the 80% target for mandatory training is sufficient.
- sharing good practice across all departments and wards in order to increase the Friends and Family Test response rate for surgery.

Outpatients:

- ensuring all staff are aware of the consent processes for patients undergoing minor surgical procedures within the outpatient department so that they are in line with best practice.
- a formal cleaning schedule in place for toys within outpatient areas.
- how it identifies issues impacting on the regular checks of emergency equipment and act to address this.
- The Trust should consider it reviews the use of personal protective equipment within the phlebotomy department in line with trust policy.
- reviewing the space within the outpatient department so that all staff are aware of and have access to space for private conversations with patients and relatives, particularly where these related to the delivery of bad news.

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 three and a half 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 19 years the Virginia Mason Production System has enabled them to become one of the safest and highest rated hospital organisations in the USA.

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 and has helped to take us from being rated 'Good' by the CQC to becoming an Outstanding organisation.

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.

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 programmes.

Sharing our work

This year we have held four 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 very proud of the significant and sustainable

SASH+ transforming care

Sue Jenkins, director of kaizen

transformation changes we have successfully made and look forward to continuing to improve the high quality of care we provide to local people. This is reflected in the recent CQC report:

"The SASH+ quality improvement programme has empowered staff by equipping them with the lean tools, methods and a structured process which has very successfully built a culture of continuous improvement across the whole Trust. Investment in improvement and training has been a priority and this had resulted in a culture where staff at all grades and from all disciplines felt involved and enthused by the work streams and the idea that they could make a real different to patient safety and the patient experience" (CQC inspection report 2019)

We are also proud of the empowering impact involvement in making change has on individuals and teams and feel that this is reflected in how our staff rank the organisation in the national NHS Staff Survey.

Research – improving clinical treatments, care and outcomes for our patients

Innovation in patient care is a Trust priority and involvement in clinical research demonstrates our Trust's commitment to improving clinical treatments, care and outcomes for our patients. By supporting research, our staff are actively working to improve the drugs and treatments offered to their patients and to improve healthcare in the future. Asking important research questions helps us to improve the quality of care we offer and contributes to the evidence base of healthcare both nationally and internationally.

Most of the national and international multi-centre studies which we invite our patients to participate in are National Institute of Health Research (NIHR) studies. Participation in these multi-site research studies gives our patients access to the latest drugs and treatments in development and also helps to ensure that our staff can offer the best care available.

Recruitment performance and targets

Our strategic aim is to encourage greater research engagement and increase research activity across our Trust. Our strong performance in research is again reflected in a significant increase in the number of patients recruited during 2018-19. For the second year running, we recruited well over 1000 patients to one of our high quality, NHS ethically approved, research studies as part of their clinical care. Against a target of 1009 recruits we were able to offer research participation to 1791 of our patients into one of the 62 research projects which have run across the Trust in different disease areas or specialties. This is a 66% increase since last year and our highest achievement to date.

We continue to perform well in respect of recruitment to research studies and in meeting national performance targets set for research. Our research

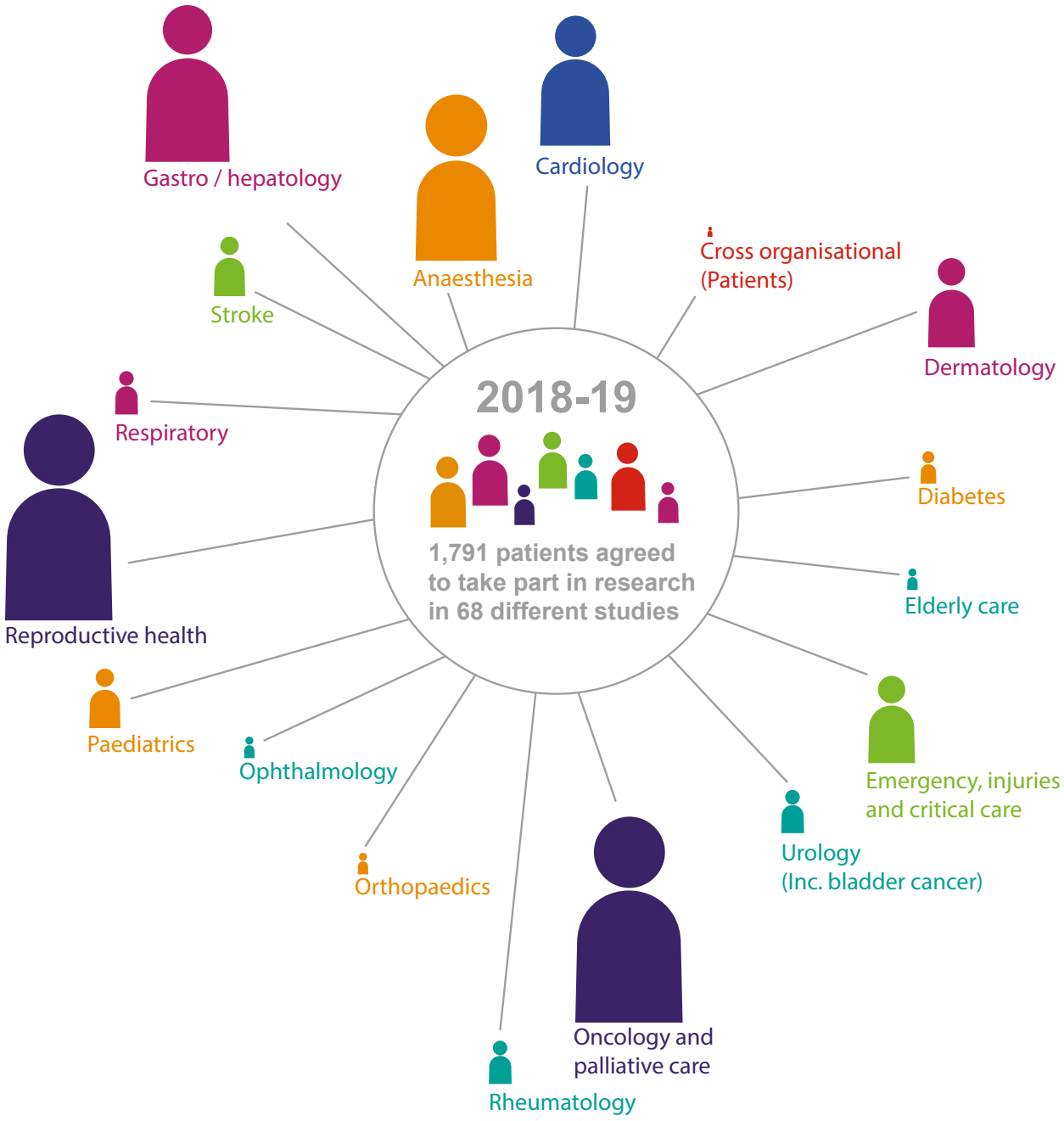
	Total participant recruitment and studies opened over last five financial years				
	2018/19	2017/18	2016/17	2015/16	2014/15
patient participants	1791	1077	817	449	771
staff participants	100	788	112	0	0
number of recruiting studies per year	62	60	54	50	45

Research

department supported the set-up of 19 new studies this year, allowing us to offer new research opportunities to more of our patients. We continue to be amongst the top recruiting sites regionally and nationally for studies and have maintained our 100% success record for recruiting to time and target for commercial clinical trials which finished recruiting in 2018-19.

In February 2019 we were very proud to receive an award from the National Institute for Health Research (NIHR) Clinical Research Network (CRN) Kent, Surrey and Sussex, recognising our achievement in meeting recruitment targets.

Patient recruitment - NIHR research studies



Patient experience

Involvement in clinical research is one way we can deliver excellent patient experiences and outcomes. A large number of our clinical specialities are engaged in research because we want to offer patients research opportunities as part of their care and believe that research activity helps to improve the effectiveness of our services.

We have a dedicated infrastructure for the support and development of research at SASH. Our specialised research delivery teams consisting of research nurses; co-ordinators and research administrators support clinical teams in discussing research study participation with patients and managing patient care on follow up and continued treatment after they enter a study.

In 2018-19 1791 patients volunteered to take part in one of the 62 research studies running at the Trust (66 % increase on 2017-18)

> **"I can't thank the staff enough, I felt so well cared for in the trial, knowing that the Consultants were available to me and that the research nurse responded immediately when I called."**
>
> Research patient participant

The research team

Our governors and members

Governors provide valuable insight and feedback from the members they represent. They work with, represent and are conduits to the members of their constituencies, helping the Trust to understand 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.

Our governors make a valuable contribution to how we deliver services and make a difference to the future health and wellbeing of local people. We consider our governors a trusted group of critical friends who make an important contribution to how we deliver care and services at SASH.

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 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.*

The Trust has around 10,200 members, 6,000 from its patient and public constituencies and 4,200 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**
- **Patient Information development**
- **Being consulted by the CQC as part of their formal inspection programme**
- **Developing a governor newsletter**

The Trust Board made the decision to recruit 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 and active however it does not have equivalent responsibilities to a similar body for a Foundation Trust.

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**
- ✓ **Continue to be a resource and sounding board for the Trust**

SASH Charity

SASHCHARITY

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.

In 2018-19, the charity's income totalled £163k and it spent £354k in year. The closing balance, as at 31 March 2018, was £682k.

The Charity Commission deadline for the submission of the charitable fund accounts for the year ended 31 March 2019 is 31 January 2020. Therefore, the accounts have not been finalised at this stage.

Fundraising activity

Support for SASH Charity included fantastic community support for the **Camomile Courtyard appeal** (detailed below) which received support from a huge range of local organisations, including local businesses, community groups, churches, schools and colleges.

In addition, many individuals, including members of Trust staff supported the campaign, by making donations, or fundraising. The courtyard was officially opened by Dame Judi Dench on 8 March 2019. Other fundraising highlights included:

- **A fundraising tea party to celebrate the 70th anniversary of the NHS; 'The NHS big 7-tea'**
- **A raffle of FA Cup tickets, kindly donated by Redhill Football Club**
- **A team of Trust staff walking the Surrey three peaks**
- **Being an official partner of the Run Reigate half marathon**

Making a difference

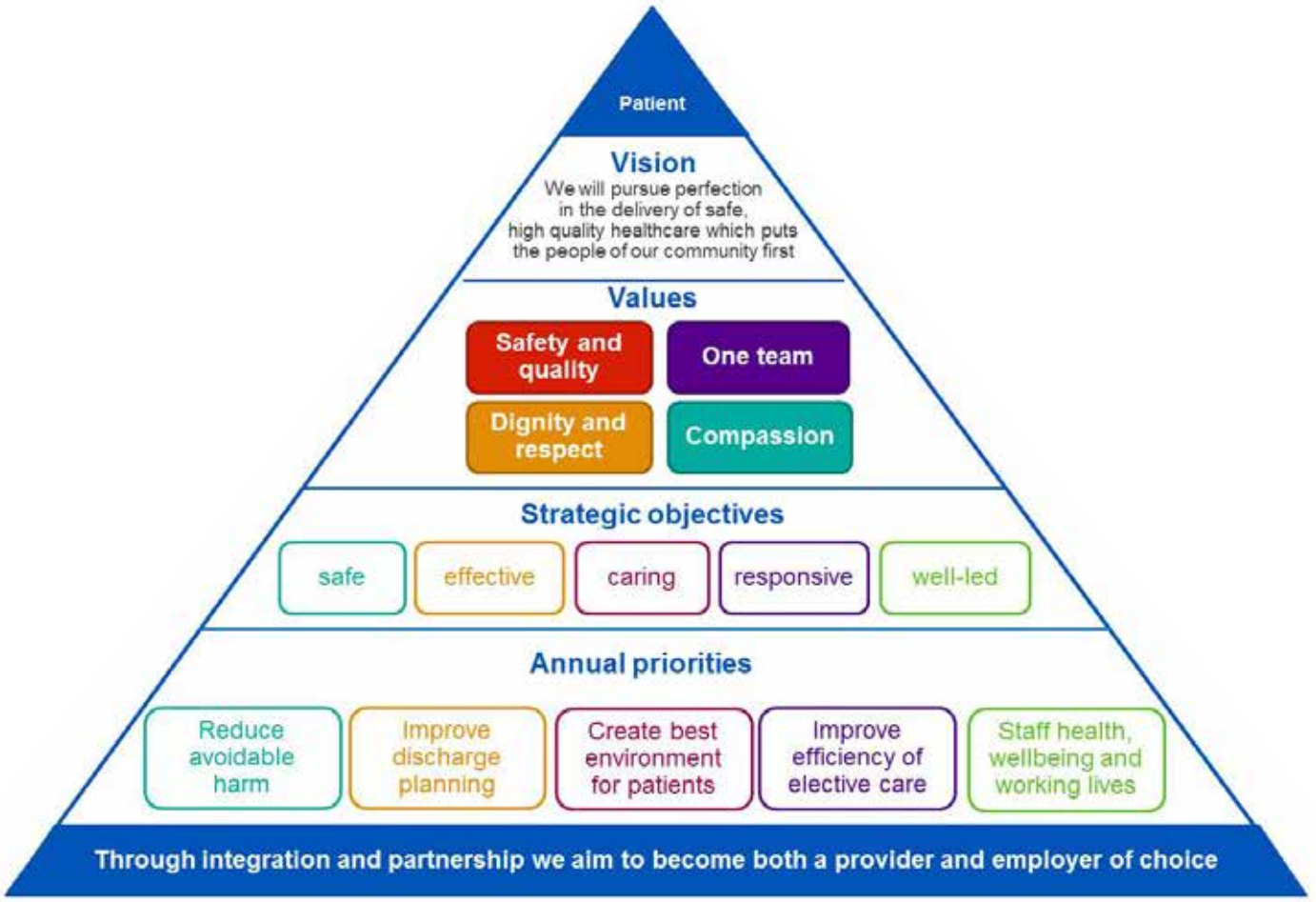
In March 2019, the charitably funded Camomile Courtyard at East Surrey Hospital was officially opened by Dame Judi Dench.

The courtyard has been completely transformed, to create a fantastic new space for patients, families, visitors and staff. It incorporates features such as; step free access from the wards and hospital corridor, non-slip flooring, raised flower beds incorporating plants specifically chosen for their sensory qualities, 1960s 'wall of recall' images and a traditional red post box to stimulate memories and conversations, as well as a table tennis table which also functions for playing a dementia friendly game.

The launch event in March 2019 brought together patients, staff, individuals and organisations who had supported the fundraising campaign. Dame Judi Dench spent time meeting people, including visiting the adjoining wards. The courtyard is a great example of the difference a trust charity can make.

Dame Judi Dench opens the Camomile Coutyard in March 2019

Our plans



Our strategy

Our strategy was reviewed and refreshed for 2018-19. During our review we were confident that the strategy was still in line with the needs of our patients, public and partners. Our strategy on a page outlines our vision, values, strategic objectives and current (previously annual) priorities.

Our strategic objectives
The strategic objectives were refreshed for 2018-19. They were amended to reflect the changing environment; the need to move towards integrated healthcare systems and partnerships; the need to work with our patients to design their healthcare and the need to use innovative IT. The revised strategic objectives are:

Safe

Deliver standardised, safe, high quality care which pursues perfection and is in the top 25% of our peers

Effective

As a teaching hospital, deliver effective and sustainable clinical services which focus on outcomes, innovation and technology

Caring

Develop the care we provide in partnership with patients, staff, families, carers and community services; deliver it with compassion

Responsive

Be the hospital of choice for our community delivering services in response to the needs of our population

Well-led

To be a high quality employer that focuses on staff health and wellbeing and delivers patient centred, clinically led, efficieint services

Our plans

Our Current priorities

We reviewed our current priorities and agreed that the annual delivery objectives were still appropriate with some minor adjustments. These are outlined below along with some of the highlights of what has been delivered in year:

Safe: Reduce avoidable harm

Our priority to reduce avoidable harm was translated into annual deliverables. The focus for 2018-19 would see the introduction of a new SASH+ value stream to increase the incidence reporting and speedier treatment of **sepsis** and increase the focus and spread of plans to reduce the number of **falls**. Mid-year, due to an increase in the incidence of **pressure damage**, this was also considered to be an added deliverable for the reducing avoidable harm priority.

Effective: Improve discharge planning

During the year we implemented our electronic patient tracking system to support proactive and timely management of patients and beds empowering our staff to care for patients in the most appropriate setting; this has resulted in a sustained reduction in length of stay.

This was also supported by our SASH+ value stream around improved discharge planning which has specifically focused on establishing accurate expected dates for discharge during the year as well as improving the process and timeliness of medication preparation for patients being discharged.

Caring: Create best environment for patients

2018-19 has seen a vast array of improvements for patients including adjustments made to outpatient waiting environments, clearer signage and sectioning within the main hospital, overall décor, ward refurbishments, a new dementia garden, new dementia friendly bright yellow toilet doors, a changing places area, suitable for people and carers with disabilities.

Responsive: Timely access to services

During 2018-19 the responsive priority was changed from improve efficiency of elective care to timely access to services. This was in recognition of the fact that all of our services had an opportunity to be more responsive. During the year responsiveness has been achieved through delivery of key performance targets, improvements in timeliness, reductions in the amount of time ambulances wait on site to hand over patients, improvements in theatre and outpatients productivity, and speedier management of complaints.

Well led: Improve staff health, wellbeing and working lives

The health and well-being of our staff has continued to be the key area of focus within our well led objective. During the year there have been various initiatives to support the health and wellbeing of our staff including, fitness classes, a health and well-being open day, increased security and the implementation of body cameras for our security guards and parking attendants to minimise abuse and violence, initiatives to encourage exercise and smoking cessation. Whilst there continue to be a significant number of initiatives aimed at improving lives for our staff there is still more to do as reflected in our staff survey and as such this will remain a high-profile area for us in 2019-20.

The areas described above give a flavour of the delivery of the Trust's strategy and current priorities but there is so much more that permeates through the organisation. All staff teams review the Trust's priorities and translate these at team level at the beginning of the year. Each team and ward area proudly present their team level objectives somewhere visible for all to see and local production boards oversee delivery of the objectives. These will be specific for the team for example, timely access to services for the pathology team might be around reporting turnaround

Our plans

Anouska Adamson-Parks, director of strategy

Our plans

times of a sample but it might be length of time for a request to recruit to new staff member being in post for Human Resources. During the year teams were provided with a wide range of data to support the development and ongoing review of the team priorities to ensure a focus on continuous improvement.

Other deliverables achieved in year include:

The key developments delivered through the annual plan in 2018-19 are:

- ✓ **Achieved an outstanding CQC rating as a Trust through the dedication and commitment of our staff**
- ✓ **A new Workforce and Organisational Development five-year strategy with annual delivery plans**
- ✓ **The development of a leadership programme**
- ✓ **Successful recruitment of nursing workforce reducing reliance on agency**
- **Implementation of fast track physiotherapy to improve access for staff**
- ✓ **New End of Life Care strategy**
- ✓ **Successful recruitment and training to SASH+ lean for leaders and taster sessions supporting even more extensive use of our SASH+ methodology**
- ✓ **Ongoing delivery of services rated as the most efficient services in the country (Model Hospital)**
- ✓ **Participation and successful delivery of service improvements from the national Getting it Right First Time (GIRFT); of particular note are the achievements within trauma an orthopaedics and general surgery**
- ✓ **Delivery of seven-day services requirements**
- ✓ **Set a strategic direction for outpatients resulting in reductions in did not attends, cancellations and improved patient experience**
- ✓ **Extended our discharge team so that all wards have dedicated complex discharge support**
- ✓ **A new ward to support system capacity issues through the winter as well as support the ongoing ward refurbishment programme moving forward**
- ✓ **Increased paediatric staffing to enhance medical support for this busy department with rising activity and acuity levels**
- ✓ **The development of a mental health strategy which has increased the focus on the need to deliver seamlessly integrated physical and mental healthcare**

Achieved an outstanding CQC rating as a Trust through the dedication and commitment of our staff

STP – working in partnership

The SASH geography and the make-up of local Integrated Care Systems (ICS) means that whilst SASH is governed within the Sussex and East Surrey ICS it has a critical role to play in the Surrey Heartlands ICS. As such the Trust has a strategic interest in both sets of plans and aligns itself accordingly. The plans that are currently set out are described below:

Sussex and East Surrey ICS (STP) - The Sussex and East Surrey ICS has spent much of 2018-19 reviewing the population demographics and formulating a view on the key priorities within the health and social care system. Alongside this has been the development of a set of shared priorities for the ICS and its component organisations. To date this has not been translated at place level. The shared priorities are outlined on the next page:

Our plans

Our shar

1 Improved health outcomes and experience for patients and population health

2. Improved quality, access and operational performance of services

3. Improved financial sustain and performance

Our shared 20

New service models and improved care quality

1. Prevent ill health and manage population health

- Embed population health management approaches and whole population stratification
- Fully implement agreed pathways for angina, atrial fibrillation and falls prevention

2. Strengthen primary and community care

- Support primary care development, increasing resilience and improving access
- Build and support the ongoing development of effective intergrated primary care networks

3. Improve urgent and emergency care

- Fully implement the new intergrated Urgent Care model, incl NHS111 CAS and UTC models
- ED redesign including implementing Same Day Emergency Care and Acute Frailty services
- Implementation of a new model of step up/down community care

4. Improve planned care

- Implement agreed STP wide plan to reduce unwarrented variation in MSK services
- Redesign planned care services to reduce the number of people waiting for treatment
- Transformation of outpatient services
- Pathology capacity development and laboratory information management system

5. Improve mental health care

- Improve the prevention of mental health
- Improve the mental health provision and support in primary care networks and in A&E

6. Improve treatment, care and support for people with learning disabilities and autism

- Reduce reliance on patient care, supporting more people to live in the community
- Reduce inequalities by increasing uptake of annual health checks

7. Improve cancer care

- Improve the early detection and diagnosis of cancer
- Improve mental and physical health services for children

8. Improve maternal and child health

- Improve maternity and neonatal services
- Improve mental and physical health services for children

ed goals

ability

4. Reforming the health and care system in Sussex and East Surrey

5. Developing a sustainable workforce and culture

19/20 priorities

System reform and STP wide enabling programmes

Implement Surrex and East Surrey system reform programme

- Support Primary Care Network development
- Develop emerging Intergrated Care Partnerships
- Implementing commisioning system reform
- Support the evolution of the SES ICS
- Continue to develop clinical networks
- Develop research and education

Digital transformation

- Full provider digitisation
- Developing a connected health and care system
- Better use of data for planning population health
- Transformed digital services for the public

Workforce planning and transformation

- Collaborative approaches to reduce temp staffing
- Improved productivity and transformation through new roles/new ways of working
- Improving workforce efficiency
- Finalise and implementation of workforce strategy

Estate planning and redesign

- Changes to the estate to facilitate delivery of the new models of care required in the system
- Maintenance and change to the existing estate to maintian its integrity, improve its efficiency and improve how services are delivered

Our plans

Priority areas of focus

1 Helping people in Surrey lead healthy lives

1.1 Working to reduce obesity and excess weight rates
1.2 Enabling prevention and treatment of increasing risk and harmful drinking
1.3 Ensuring that everyone lives in good and appropriate housing
1.4 Promoting prvention to decrease incidence of serious conditions and diseases
1.5 Helping people to live independently for as long as possible and to die well

2 Supporting the emotional wellbeing

2.1 Enabling children, young people, adults and elderly with mental health to access the right help and resources
2.2 Enableing emotional wellbeing of mothers throughout their pregnancy
2.3 Preventing isolation and enabling support for those who do feel isolated

3 Supporting people in Surrey to fulfil their potential

3.1 Enabling children to develop skills for life
3.2 Enabling adults to succeed professionally

Surrey Heartlands ICS - During 2018/19 Surrey Heartlands has commenced its devolution journey by considering the needs of the population and developing a 5-10-year strategic plan (summarised below in terms of priority areas and the target populations). Whilst plans are at a high level this is now being translated into outcome measures and KPI ambitions. To date this has not yet been translated at place level.

Target population cohorts

a **General population**

b **Children with SEND and adults with learning disbilities and/or autism**

c **Young and adult carers in Surrey**

d **People who need support to live with illness, live independently, or to die well**

e **Deprived or vulnerable people**

Patient experience

What our patients say

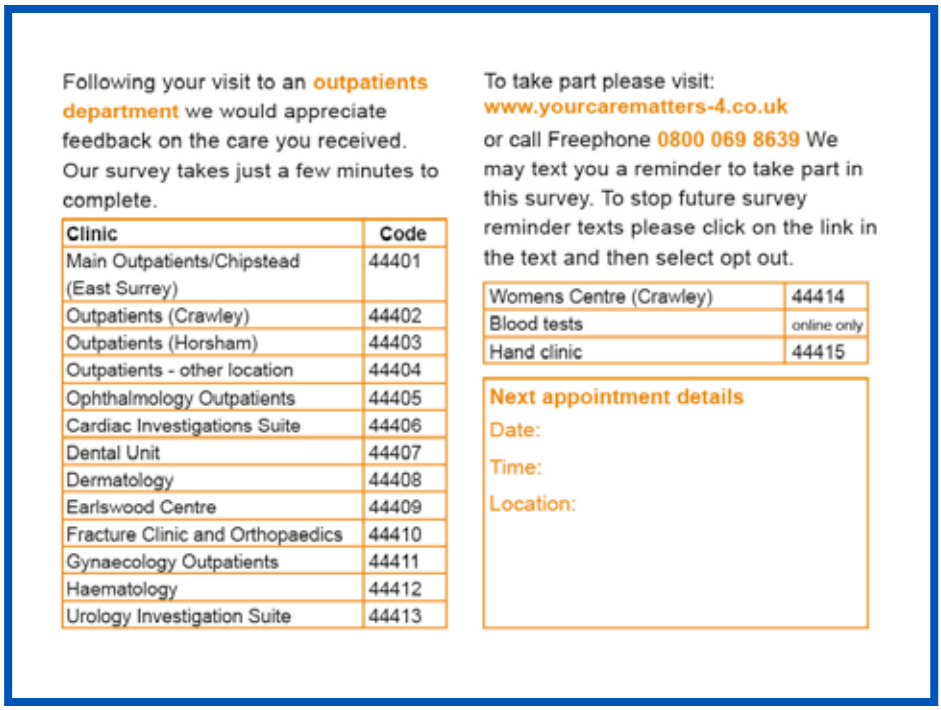
Since the Trust has launched its bespoke patient experience platform in March 2017, it has gone from strength to strength. The Meridian system allows information to be filtered to different niche specialities, wards and services. It was recognised that other trusts have improved the amount of completed 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.

Your care matters

The cards **(pictured left)** are produced in different colours for different specialities and divisions. The cards provide details of Freephone numbers and specific website links to ease the process for patients to complete the surveys.

Care opinion

The care opinion website that is independent provides reassurance to patients that their concerns are listened to. Each clinical area has designated staff who are responsible for responding to comments when they are posted and this continues to be very helpful for the organisation.



Following your visit to an outpatients department we would appreciate feedback on the care you received. Our survey takes just a few minutes to complete.

Clinic	Code
Main Outpatients/Chipstead (East Surrey)	44401
Outpatients (Crawley)	44402
Outpatients (Horsham)	44403
Outpatients - other location	44404
Ophthalmology Outpatients	44405
Cardiac Investigations Suite	44406
Dental Unit	44407
Dermatology	44408
Earlswood Centre	44409
Fracture Clinic and Orthopaedics	44410
Gynaecology Outpatients	44411
Haematology	44412
Urology Investigation Suite	44413

To take part please visit: www.yourcarematters-4.co.uk or call Freephone 0800 069 8639 We may text you a reminder to take part in this survey. To stop future survey reminder texts please click on the link in the text and then select opt out.

Womens Centre (Crawley)	44414
Blood tests	online only
Hand clinic	44415

Next appointment details
Date:
Time:
Location:

Patient Advice Liason Service (PALS)

On average PALS have just over 350 contacts per month whilst continuing to diffuse many situations. PALS offer practical solutions and a listening ear in real time.

Contacts are made via walk-ins, telephone, letters and emails. PALS intervene so that potential reasons to complain can be managed proactively.

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.

The PALS team consists of four part time officers who are overseen by the Patient Experience Lead. The whole team are based in the PALS office. The office has been redesigned to provide a more comforting space for patients and their relatives, with the service operating Monday to Friday 9.30am to 4.30pm. The previous advice and information database has been updated to DATIX, which will now synchronise with the rest of the PALS cases reported. PALS have a monthly team meeting where other departments are invited; this is working to build a much better understanding of building relationships within the Trust. PALS main objective is to resolve situations from becoming complaints where possible.

Supporting carers

Our carers steering group will be relaunching to meet again bi-monthly. The steering group allows us to focus and improve work in identifying and supporting carers in a consistent and effective way. Carers Support Group is located in the PALS office every Tuesday afternoon, which allows direct referrals and this is reassuring for the patient and their carers.

Carer's Passport

The carers' passport is recognised throughout 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. Divisions are reminded regularly at the patient experience committee to share the benefits of advocating this passport to their team members.

Open visiting

Wayfinding - 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 list of services and also the provision of decision boards enable patients to quickly decide which way they need to turn at junctions, eases the patient journey. Plans for 2020 will be to replace the outside signage.

Noise at Night - This is a topic that is often highlighted in patient feedback. The divisional chief nurses and Patient Experience Lead are in discussion of finding solutions how to best combat the matter in a feasible system.

Dementia - Every last Wednesday of the month, from 3pm to 4pm the Trust have a Dementia Café which is located in the Three Arches Restaurant, East Surrey Hospital and dedicated to dementia patients and their carers'. The café is an opportunity to remove isolation and bring this target group together. The Trust have the Camomile Courtyard dedicated to Dementia patients.

Clinical staffs wear yellow name badges which are dementia friendly. The emergency department is planning to make four of the bays dementia friendly. The Dementia Steering Group consists of a multi-disciplinary of professionals who work on strategies to improve the dementia patient experience and journey.

Patient Stories - Each patient experience committee meeting has a patient story that is rotated for the divisions to share. The stories form 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. The Trust are always receiving numerous compliments through our

Patient experience

senSASHtional 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 telephone calls from patients wishing to extend their thanks and gratitude to the trust teams.

Compliments received in PALS are always passed onto the relevant department to share with staff. **(See examples illustrated on the right)**.

> *"Fast and efficient A&E Department."*

> **"I had wonderful care from all the staff on the birth unit, delivery suite and eventually theatre. We felt supported throughout and all the staff were caring and professional. I was extremely impressed with your service."**

> *"Once again I was seen at the exact time of my appointment."*

Making it better- responding to complaints

One of our strategic objectives is to develop the compassionate care we provide using feedback from our patients. Issues raised within complaints help us to understand the needs of patients and where service improvements can be made. In the first instance 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 2018-19 the Trust received 601 formal complaints an increase from 2017-18 (542). 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 identified were in the categories of care implementation and attitude/ courtesy of staff in 2018-19. These were:

Care Implementation: problems relating to diagnosis and general nursing and medical care featured in 135 complaints in the 12-month period. This is a very broad category and is therefore the main theme within

Patient experience

> **"The communications were handled compassionately and I wasn't made to feel like a nuisance. The timescales were very reasonable. The online form gave the opportunity to be descriptive and detailed."**

> ***"The friendly manner in which I was dealt with. At no time was I made to feel I was being a nuisance, I was also assured that my issue would be rectified. My sincere thanks to the staff who spoke to me."***

our complaints.

Each complaint is thoroughly investigated and scrutinised before feedback is given to the complainant. We offer each complainant a choice of how to receive this feedback; most complainants choose to receive a letter, but where the complaint is complex, a meeting is often preferred. Working together the Trust aims to restore the confidence of patients or carers, who have had cause to complain.

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 2018-19 the complaints team achieved this target in 100% of cases. We aim to respond to all complaints within the timescales agreed with the complainant. Over the course of the year this was achieved in over 90% of cases.

The complaints team actively solicit feedback on the complaints process from patients or carers who have had cause to use it. **(See examples of positive feedback illustrated on the left)**.

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 (shown right).

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.

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.

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.

%age of patients readmitted within 28 days of discharge			
	Standard	2017-18	2018-19
ED 95% in 4 hours - LAEDB Performance	95%	95%	96%
ED 95% in 4 hours - Trust Performance	95%	92%	93%
Patients Waiting in ED for over 12 hours following DTA	0	0	0
Cancer - TWR	93%	93%	94%
Cancer - 62 day Referral to Treatment Standard	85%	87%	82%
RTT Incomplete Pathways - % waiting less than 18 weeks	92%	89%	91%
RTT Patients over 52 weeks on incomplete pathways	0	19	9

Table: Performance against key national standards

%age of patients readmitted within 28 days of discharge				
	2017-18	2018-19	Change	%change
Emergency attendances	99,071	105,325	6,254	6.31%
Outpatient appointments	374,006	395,526	21,520	5.75%
Non-elective admissions	36,276	38,398	2,122	5.85%
Births	4,516	4,499	-17	-0.38%
Elective admissions	48,569	52,419	3,850	7.93%

Table: Activity numbers

	Q1			Q2			Q3			Q4		
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ED 95% in 4 hours - LAEDB performance	97.6%	98.7%	98.3%	97.4%	97.0%	97.6%	97.6%	96.3%	93.7%	90.6%	93.2%	95.9%
ED 95% in 4 hours - Trust performance	95.5%	97.9%	97.1%	95.5%	97.6%	95.6%	93.1%	92.6%	88.8%	83.2%	88.0%	93.1%
Patients waiting in ED for over 12 hours following DTA	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance turnaround - number iver 60 mins	26	0	1	5	3	0	26	7	78	164	8	6
Cancer - TWR	93.0%	93.1%	93.2%	94.1%	93.1%	93.0%	93.6%	93.4%	95.2%	93.2%	94.2%	93.0%
Cancer - 62 day referral to treatment standard	84.0%	81.2%	80.8%	81.5%	79.6%	87.7%	86.3%	87.9%	85.7%	74.9%	78.0%	81.1%
RTT incomplete pathways - % waiting less than 8 weeks	89.9%	90.7%	90.0%	90.0%	89.4%	89.1%	89.5%	90.2%	89.3%	90.0%	90.2%	90.6%
RTT patients over 52 weeks on incomplete pathways	16	15	8	10	16	16	13	9	10	13	11	9
Percentage of patients waiting 6 weeks or more for diagnostic	0.2%	0.1%	0.4%	0.4%	0.7%	0.1%	0.1%	0.5%	0.7%	1.3%	0.9%	1.1%
No of operations cancelled on the day not treated within 28 days	0	1	5	2	0	0	1	3	6	8	TBC	TBC

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) continued to be a significant challenge across the country throughout 2018-19 and the delivery of the standard continues to be a key priority for the Trust and the local health system.

As a local system, we delivered the standard with performance of 96% across the year, but with some challenges in the winter months, and improved on the 2017-18 performance of 95%. Performance for the East Surrey Hospital Emergency Department also improved in 2018-19 with performance of 93%, but with similar challenges over the winter months.

At both Local Accident and Emergency Delivery Board (LAEDB) and Hospital level our performance significantly exceeded the national average and was consistently one of the top performers across the country.

In 2018-19 we continued to embed the Ambulatory Care Unit and Frailty Unit which have had a significant positive impact on the emergency care value stream. We also undertook a number of other pieces of improvement work including embedding a digital patient flow / command centre system. The Trust has continued to work as part of the 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.

Cancer waiting times

Cancer access targets have remained a significant focus for us this year, during which we have seen a number of challenges including ongoing growth in cancer referrals. Despite this growth, the Trust successfully achieved the two week rule (TWR) standard in all quarters of 2018/19 and overall for the year we saw an increase in performance from 93% to 94%.

However, the 62 Day Standard saw a number of issues across the year which resulted in the standard only being achieved in Q3 of 2018-19 and overall performance of 82% for the year compared to 87% in 2017-18.

Like emergency care, cancer has been a challenge nationally and many of the local issues are also a reflection of national challenges e.g. diagnostic capacity.

We continue to work to improve pathways to support the implementation of the national cancer strategy, and our internal and joint work as part of the Surrey and Sussex Cancer Alliance 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.

While the Trust has not achieved the incomplete target since November 2016, there has been significant improvement during the year with a reduction in the overall waiting list, a 50% reduction in patients waiting over 52 weeks to start treatment and for 7 months of the year, performance against the incomplete standard has been over 90%, well above the national average.

We had planned to achieve the incomplete standard during Q3 of 2018-19 and made significant progress on a number of specialties, notably neurology and dermatology, but further challenges around

referral growth and internal capacity meant this ambition was not achieved in 2018-19 and now forms a key objective for 2019-20.

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 January and March 2019 performance fell below expected levels when we saw un-precedented demand for Endoscopy as well as an MRI scanner breakdown.

Michael Wilson CBE
Chief executive
Date: 29 May 2019

Emergency department

Digital conversations

We continue to see a steady rise in visitors and traffic to our website and social media channels. Digital communications continues to be central to the delivery of communications activities at SASH and externally.

Our website provides clear information which is easy to access and find, to our patients, visitors and staff. Our social media channels encourage conversation among our social media audience, promoting positive engagement.

Our social media channels also raise the profile of the Trust and positively promote its work and reputation.

The number of people engaging with SASH through our social media platforms continues to grow.

Twitter
@sashnhs

Followers

March 2018:	March 2019:
11,256	**11,928**

672
new followers in the past year

LinkedIn
www.linkedin.com/company/surrey-&-sussex-healthcare-nhs-trust

Followers

March 2018:	March 2019:
1,904	**2,473**

569
new followers in the past year

You Tube
www.youtube.com/user/sashnhs

Subscribers

March 2018:	March 2019:
209	**313**

27,911 views in the last year
71,925 minutes

Most watched video: Your Operation at East Surrey Hospital
9,986 views

Website

1,176,773 page views (page views are the total number of pages viewed. Repeated views of a single page are counted).

295,554 users to the site, 471,742 sessions (a session is defined as a group of interactions one user takes within a given time frame on the website. Google Analytics defaults that time frame to 30 minutes, meaning whatever a

Performance

Facebook
www.facebook.com/sash.nhs

Followers

March 2018:	March 2019:
2,461	3,156

3,082
new likes in the past year

695
new followers in the past year

Instagram
@sashnhs

Followers

March 2018:	March 2019:
684	1,098

414
new followers in the last year


Pareeta Nayee, digital communications manager

user does on your website (e.g. browses pages, downloads resources) before they leave, equals one session.

5,778 sessions came via social media (1.22% of sessions)

Facebook
4,183 sessions
72.40%

Twitter
1,241 sessions
21.48%

LinkedIn
326 sessions
5.64%

Instagram
12 sessions
0.21%

YouTube
3 sessions
0.05%

Other*
13 sessions
0.22%
***Pinterest, Blogger, Weebly, Yammer**

Our people

Who we are

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 are we				
Staff group	Headcount	% of workforce	% female	% male
Add Prof Scientific and Technic	124	2.79	79.84	20.16
Additional Clinical Services	816	18.37	78.43	21.57
Administrative and Clerical	885	19.93	83.84	16.16
Allied Health Professionals	213	4.80	84.04	15.96
Estates and ancillary	379	8.53	48.28	51.72
Healthcare Scientists	83	1.87	68.67	31.33
Medical and Dental	649	14.61	49.00	51.00
Nursing and Midwifery Registered	1291	29.07	89.78	10.22
Students	1	.002	100	0.00
Grand total	4,441			

Staff survey

National NHS Staff Survey
We received a fantastic response to the 2018 National NHS Staff Survey – over 64% of staff completed the survey and our results were equally impressive. Whilst there have been amendments to the way the results have been reported, of the Key Findings that are still comparable with the 2017 survey, SASH scored a 'significant increase' in 7 of these and also a 'significant increase' in staff engagement. Compared directly to other Acute Trusts, SASH were the top ranked for five of the key findings and in the top five for 17 of the key findings. As well as being second highest nationally for staff engagement. We were third nationally 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.

Where we are in the top five Acute Trusts nationally

Staff have fed back positively in the following areas:

- ✓ Staff recommendation of the organisation as a place to work or receive treatment
- ✓ 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
- ✓ Quality of appraisals

Our people

- ✓ 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
- ✓ Percentage of staff reporting their most recent experience of harassment, bullying or abuse
- ✓ Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- ✓ Staff feeling there is the effective use of patient and service user feedback

Whilst this provides a positive overview, there is still work to do in relation to staff facing abuse, both physical and verbal from patients, relatives and ensuring this is reported so the Trust provides support appropriately and takes relevant action.

Following the 2017 survey, we have already began work with teams, particularly in the Emergency Department, where incidents occur more frequently so we can understand how incidents occur and what actions can be taken to minimise these. The overall key finding scores have improved, but we will continue our work to ensure all of our staff have a safe environment in which to work, without fear of abuse from service users, relatives and the public.

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.

Staff Friends and Family Test

The NHS Friends and Family Test (FFT) are used widely throughout the trust as a measurement of patient feedback. FFT provide an excellent learning tool for the Trust to recognise issues that need to be addressed.

All FFT results are provided to divisions prior to monthly patient experience committee meetings; so that issues and trends are discussed to seek solutions.

Overall FFT Scores 2018-19

Over the financial year our Friends and Family tests score has been consistently over 93%.

"Once again our national staff survey scores show how well engaged staff are with the organisation and that their commitment, dedication and support drives our on-going journey of continuous improvement"

Michael Wilson CBE
Chief executive

Our people

Overall FFT Scores 2018-19

Over the financial year our Friends and Family tests score has been consistently over 93%.

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.

2018 marked our largest award ceremony with over 210 staff attending. 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.

To celebrate the NHS 70th Birthday, we added an additional award for lifetime achievement. Our awards showcase and recognise 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
- NHS Lifetime Achievement

Developing our staff

We have been progressing work streams to support the implementation of the education and development strategy and operational plan which was approved by the Trust Board in January 2018.

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

Our key areas of work / successes aligned to strategic objectives include:

Education and training policy development and establishing the mandatory training group to involve key stakeholders in a programme of continuous improvement.

Increased and maintained mandatory training compliance exceeding the Trust KPI of 80%. This has been achieved through a range of strategies such as streamlining internal provision, increased reminders and closer working with key stakeholders.

Exceeded the Trust achievement review (appraisal) target of 90% and quality of appraisal is ranked as the highest for acute Trusts in the 2018 national staff survey.

Over 60 apprentice learners enrolled providing development opportunities to existing staff.

Our people

Booking and patient experience team

Deep cleaning team

Our people

Programmes are offered over a diverse range of areas, for example painting, hospitality, healthcare science, pharmacy support, team leading and management, trainee nursing associates from levels 2 – 7. This is significant progress from the previous year and enables the Trust to utilise the apprentice levy to support professional and career development and create pipelines of talent.

Established trainee nursing associate apprenticeship programme with 32 internal staff recruited onto programme between March 2018 and February 2019. The Trust has led work with partners across the STP to establish a Nursing Associate Consortium working with HEE and the training delivery partner the University of Brighton. Trainees will complete a foundation degree and inter- organisational placements across a range of healthcare settings. On successful completion staff will be eligible to join the NMC register in the new role of Nursing Associate. This role bridges the gap between nursing assistant and registered nurse and will play a key role in providing direct care.

Scoped and commenced project to develop a strategy for development and education of Advanced Clinical Practice roles. HEE has developed a new framework to provide a consistent approach to developing advanced practice roles, applicable across all professions. SASH has been able to appoint a part time project lead for 12 months to lead a project focusing current and future workforce needs, education pathways and governance to ensure patient safety.

Developed SASH leadership development framework and career development tool. Through working with a trusted external partner and internal pilot groups we have developed a leadership framework at four different levels aligned to the trust values. The career development tools provide current and aspirant leaders a means of self-assessing against the leadership framework and reflect on their readiness and development needs for future roles.

Increased participation in personal development programmes across a range of topic areas including customer care, resilience and conflict resolution and we launched a new foundation coaching skills programme.

Successful uptake of train the trainer workshops and mentor training through academic modules and internal updates to support development of our internal faculty of educators and work-based supervisors.

We funded staff to complete external short courses and academic programmes to support continuing professional development to support service delivery and specialist development pathways.

We facilitated access to over 150 work experience placements for school students and charities seeking opportunities for people with learning disabilities.

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

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.

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.

Our people

In 2018-19, no members of staff were on off-payroll engagements for more than £245 per day and more than six months, (0 in 2017-18).

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.

Our staff engagement score in the 2018 national staff survey improved from the 2017 survey and we were the second highest ranked acute trust nationally for this.

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 64% in 2018, which was the 4th highest 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 FSUG Ambassadors**
- **Guardian of Safe Working**

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.

Mean hourly rate	Male	Female	Diff%
AFC	£13.82	£14.94	-8%
Medical	£34.52	£27.76	20%

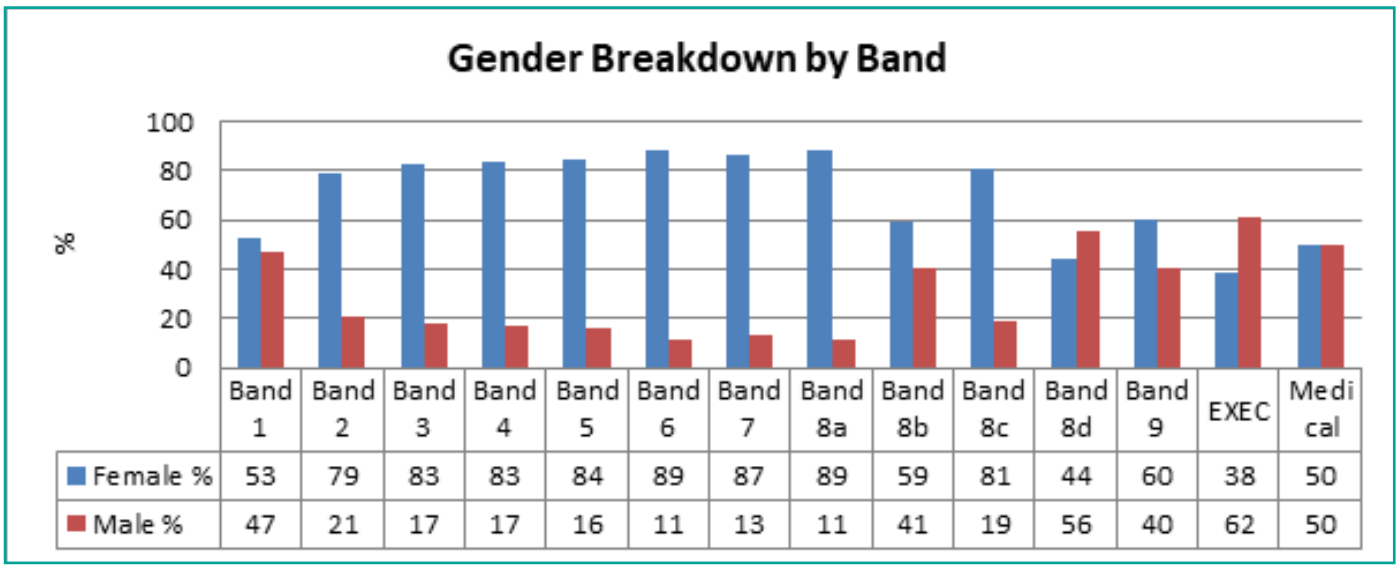
Median hourly rate	Male	Female	Diff%
AFC	£11.83	£13.63	-15%
Medical	£34.68	£26.47	24%

Addressing the gender pay gap

Gender pay gap reporting came into effect from 6 April 2017, with the data being published from April 2018. It is a legal requirement that all organisations with over 250 or more employees publish data about their gender pay gap on an annual basis. As well as reporting via the Government's online reporting portal, SASH also publish this data on their website.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The gender pay gap shows the difference between the average (mean and median) earnings of men and women. This is



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	EXEC	Medical
Female %	53	79	83	83	84	89	87	89	59	81	44	60	38	50
Male %	47	21	17	17	16	11	13	11	41	19	56	40	62	50

expressed as a percentage of men's earnings.

Our gender split by pay-band shows that the significant majority of band 2 to 8a's are female while the split is more even at higher bands:

The Trust is developing actions to reduce the pay gap (e.g. supporting female medical and dental staff applications for excellence awards). We will also be looking more widely at the pay gap for other protected characteristics.

Our people

Imaging and diagnostics

Our people

Equality, diversity and human rights

During 2018-19 we finalised and launched the SASH One Team Inclusion Strategy. This sets out our vision to ensure that inclusion is central to everything that we do.

We have set up an executive level Inclusion Steering Group, (ISG), which is chaired by the SASH Director of Kaizen. This ISG meets monthly and its purpose is to oversee the on-going development of a fully inclusive environment and culture at SASH. This will provide a framework for inclusion for our staff, our patients and service users, and the wider community.

We held our first Trust-wide inclusion conference in February 2018, which celebrated inclusion at SASH. This event included internal and external speakers as well as performances from the Include Choir.
From the 2018 Staff Survey results, 74% said that the organisation made adequate adjustments to enable them to do their job (which is above the national average).

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. We will continue to develop our inclusion strategy based on feedback from staff, service users, and other groups as appropriate to supports the delivery of this. We have also met our Public Sector Equalities Duties.

Freedom to Speak Up

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.

Guardian for Safer Working

In accordance to the Junior Doctors Contract 2016, the Trust appointed Dr Virach Phongsathorn as our Guardian for Safe Working Hours in June 2016. The Guardian's role is to oversee the welfare

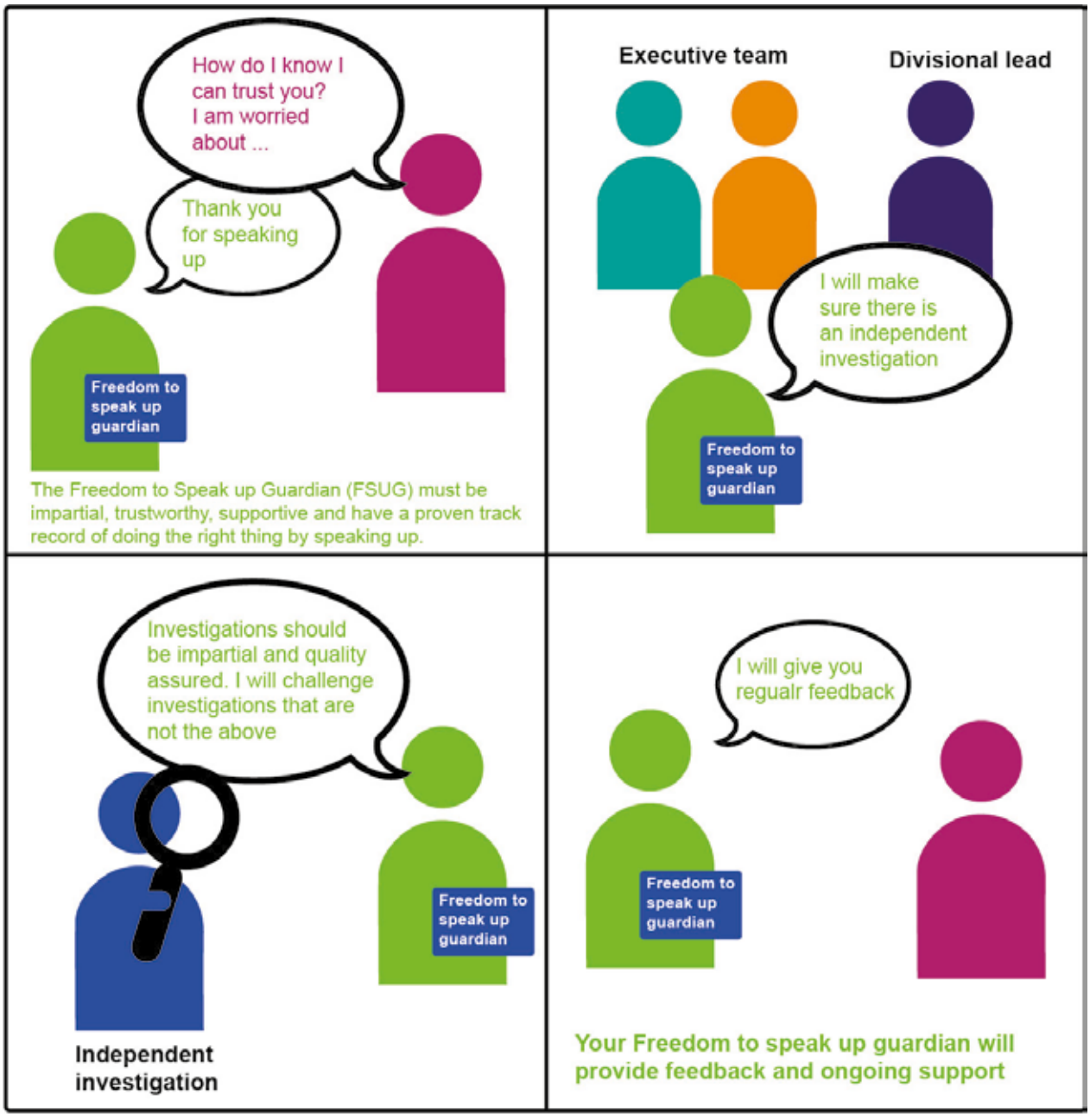
Catherine Sharpe
Freedom to speak up guardian

of doctors in training in relation to their working hours, work intensity, ability to have adequate rest breaks during their working hours, and to ensure that they are able to attend their educational activities unimpeded. While the Guardian is accessible at anytime when needed, the formal channel of communicating the difficulties that arise is through the usage of 'exception reporting' which is done electronically.

Once submitted, there is a clear pathway by which the issues arisen are attended to by the supervisors of the trainees involved and a well laid out escalation options. The Guardian reports directly to the Trust Board but also have access to the Chiefs and executives when needed.

The Guardian is required to provide a formal report to the Trust Quarterly and the Guardian's Board Reports are embedded on the Board Agenda which is accessible by the general public.

Freedom to speak up
The speaking up process



Our people

Surrey Choices

We continue to work in partnership with Surrey Choices to offer work experience to young adults with disabilities.

The aim is to equip young disabled people with the skills and confidence they need in order to live independent and fulfilling lives and to be able to gain paid employment. Work experience is a key element of this process giving students the opportunity to experience the work place and develop their communication and job-related skills. A small number of students have benefitted from this opportunity.

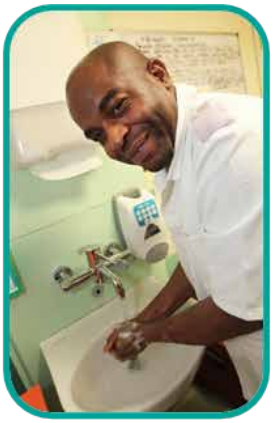
The Trust has also offered work experience to a mature student seeking to develop confidence and skills to secure employment after a period of mental health illness.

We remain committed to supporting all members of our community to have equal access to employment.
Black, Asian, minority ethnic staff network (BAME)

Lesley Copus, occupational health

Our people




Black, Asian, minority ethnic staff network (BAME)

The role of the Black, Asian, minority ethnic (BAME) staff 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 network is an inclusive staff network, open to all including non BAME members who are interested promoting race equality and inclusion. The SASH BAME staff network was launched in 2017-2018 and now has over 60+ 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 the experience for BAME patients treated within our 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.

Achievements of the network in 2018/19

- Re-launched the network and set-up a steering group (currently seven members)
- Promoted the network trust-wide and increased membership including dedicated section on SASHnet
- Confirmed CEO board champion
- Contributed to the recruitment of Freedom to Speak Up Ambassadors (FSUA) now included five staff from BAME backgrounds
- Participated and gave feedback in the BAME focus group as part of the recent CQC inspection
- Input in the development of the Trusts One Team Inclusion Strategy
- Facilitated a BAME session with Mental Wellbeing and Resilience workshop
- Celebrated Black History Month
- Circulate training, development opportunities to network members

Our people

Finance team #CelebratingDiversity at SASH during Black Histoty Month

Our people

'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 and Company Secretary
and Chair of the BAME staff network steering group

Accessing hard to reach groups

Patient experience lead is working closely with the Engagement and Partnership Officer from Surrey County Council, to build relationships with the hard to reach groups. The target groups are Disability, End of Life, Travellers and BAME. The aim is to understand and find ways that the Trust can be more accessible to these groups.

Occupational health, safety and wellbeing

Occupational Health continues to take a proactive approach towards staff health, wellbeing and safety. This year the department has supported the recruitment of staff, (processing 2587 pre-employment requests for all types of staff); providing clinics and consultations, (which are delivered by a specialist team of nurses and a visiting doctor); contributing towards staff safety by more than doubling the number of immunisations and blood tests undertaken in year, (eg. for measles, MRSA and TB); following up all work-related staff absences and incidents to create a safe and supportive environment for our staff; developing and expanding our training programmes has improved reporting and compliance of health and safety incidents.

SASH active

Wellbeing and SASH active

We are keen that staff take care of their wellbeing and we have promoted regular wellbeing activities through our SASH Active campaign. The wellbeing day that was delivered in September 2018 was the most successful to date, with some 52 exhibitors and more than 800 attendees.

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 which support both mental and physical wellbeing. 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 the flu vaccination

Our Volunteers

Volunteers continue to play an important role in supporting our staff and patients and as part of the NHS long term plan, the Trust will continue to build on our successes of working with volunteers.

The volunteer workforce is a loyal and highly dedicated group, many of whom have worked at SASH for many years, six having worked at the hospital for over 25 years, making an invaluable contribution to the local community.

Volunteers are a valuable asset whether their work involves sitting with an anxious patient, providing reassurance, cutting up a patient's food or providing reception support in the evenings.

Key areas of focus in 2018-19, included a programme of training for all volunteers and the development of new roles. Dementia, basic life support, statutory and mandatory and feeding training have been delivered. New roles have included hospital hosts, mealtime support, speech and language support, and providing assistance with physiotherapy and Mouthcare Matters.

Our people

The Trust works closely with partner organisations to provide volunteering opportunities and this year there have been several success stories with volunteers transitioning into paid employment within the hospital.

The volunteer trolley service continues to be a popular service and provides snacks and drinks to patients and their visitors at the bedside. The scope of the trolley service has been increased to three days a week and there are plans to further extend the hours of operation. Funds raised from the service have allowed volunteer uniforms to be purchased, volunteer marketing material to be developed and several events to be hosted for volunteers celebrating their work and contribution.

Radio Redhill has 70 volunteers who visit the hospital wards talking to patients, collecting their 8000 music requests every year and then playing them on the daily request programmes. Radio Redhill can be heard on ward headsets and on personal radios on 1431AM and online.

Highlights over the past year include winning a Gold Award in the 2018 Hospital Radio Association Awards for our entry covering the visit of the Flying Scotsman to the Bluebell Railway. Sian Wallis, a committee member and trustee of Radio Redhill, received a Volunteers Award from the Mayor of Reigate and Banstead for her service to hospital radio.

> **"Our volunteers are a key asset to SASH, and year on year our volunteer programme continues to grow. The range and scope of volunteering is fantastic to see and I thank all of our volunteers for their time and dedication to supporting the Trust deliver first class care"**
>
> **Richard Shaw**
> **Chair**

The Macmillan Cancer Support Centre is open to anyone affected by cancer and offers holistic care in a relaxed, quiet space. The centre offers support and information, as well as complementary therapies, psychological and emotional care, activity groups, for example yoga and art, and various courses and groups. Led by the Centre Manager, there is an increasing team of information and support volunteers, therapists and activity teachers, and the service continues to offer crucial support to those affected by cancer.

Work experience students and career events

The Trust recognises the importance of offering work experience opportunities to young people to encourage a career in healthcare. We aim to provide insight into a chosen career which may assist young students in the decision to pursue a specific career. Placements are highly sought after and we offered 176 placements during 2018-19. It is a great way to encourage future generations and put students on a career path to becoming NHS staff of the future.

The Trust's many professional groups represented their chosen discipline at local career events. Two events were hosted by SASH: Meet the Practitioner and our Health and Social Care Autumn career fair which we both hugely popular and successful. Practitioners reported a high level of interest and informed questions and welcomed the event as an opportunity to share their passion for their profession.

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 people

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 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.

The Friends of East Surrey Hospital have donated nearly £4.0m to the Hospital since 1990.

In 2018, the Friends of East Surrey Hospital made 23 grants to SASH totalling £236,000 including:

- £76,000 for a Liver Fibroscanner
- £50,000 for a Specialist echocardiograph
- £11,000 for 15 Z beds for Palliative Care
- £4,000 for tables and chairs for the Sunshine Nursery
- £1,700 for four CD players for Radio Redhill

Other grants were made to support;

- The Hospital gardens
- Floral arrangements for the Front Desk at the Main Entrance
- The Sunshine Nursery's annual outing
- Christmas gifts for the wards and departments

*charity number 287535

Richard Burford BEM, chair The Friends of East Surrey Hospital

Our environment

Sustainability at SASH (Care Without Carbon)

Our vision to pursue perfection in the delivery of safe, high quality healthcare that puts the people in our community first is intrinsically linked to developing a truly sustainable approach healthcare. With this as a guiding principle, we are working towards three key aims:

- long term financial sustainability
- minimising our impact and even having a positive impact on the environment
- supporting staff wellbeing to enable a healthy, happy, productive workforce

We have set out how we will achieve these aims in our Sustainable Development Management Plan (SDMP) called Care Without Carbon (CWC) at SASH. CWC sets out the actions we need to take across seven elements of the organisation to ensure a co-ordinated approach.

The seven elements are designed to integrate sustainable thinking and planning, into core operational activities so that it becomes part of business as usual and key to the way the Trust functions.

Delivering more sustainable healthcare through our seven elements

Our SDMP adopts the CWC framework for sustainable healthcare, with work streams covering seven different elements. See SASH's seven elements of sustainable healthcare illustrated above.

The Trust's director of information and facilities is our executive lead for sustainability, and each of the seven elements has a senior lead within the Trust. Responsibility for delivery of each element sits with this senior lead, who is also tasked with ensuring that this sustainability programme aligns with any strategic goals and priorities within their area of expertise at the Trust.

Key highlights from 2018-19

Highlights from our sustainability programme this year include:

- **driving change across our Sussex and Surrey Sustainability and Transformation Partnership (STP) area through a joint Energy Performance Contract (EPC). This will deliver new energy**

saving infrastructure to our main hospital site, saving the Trust money and cutting our carbon footprint over 15 years

- **working with local NHS trusts to deliver a joint waste tender, bringing cost savings and setting stringent KPIs for our contractors to help us deliver against targets set in our SDMP**
- **launching a new staff engagement programme, Dare to Care, to support delivery of our SDMP**
- **cutting our plastic use within the Trust through switching to compostable cups in our restaurant, and launching a staff pledge to use #oneless piece of plastic**
- **transferring onto a renewable energy contract on 1 April 2018**
- **securing £500,000 in funding for LED lighting from the Department of Health**

Environmental impact

Our carbon footprint

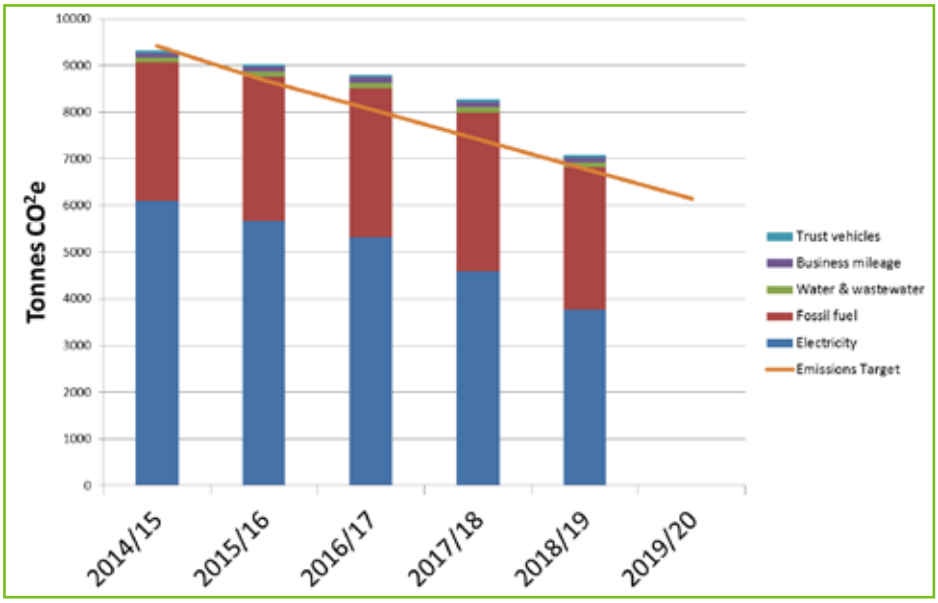
In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also transport Trust staff, patients and goods, and purchase a large range of medical and other equipment and services. All of these activities generate carbon dioxide (CO_2) emissions, 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 2,238 tonnes CO_2e (24%). We are very close to our in-year target for 2018-19, marking our trajectory towards a 2020-21 target of 34% reduction, in line with national NHS requirements (see SASH carbon emissions to 2020-21 diagram, shown right).

Note: Figures relate to our primary site, East Surrey Hospital only. Due to the date of

Our environment

SASH carbon emissions to 2020-21



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.

Progress against our seven elements

Leadership:

Leading the way for sustainable healthcare policy and practice.

2020 target: publish an annual sustainability report tracking progress against the SDMP Care Without Carbon at SASH. In particular showing how the key SDMP targets are being met.

Our progress:

We have expanded the reporting on sustainability within the Trust's Annual Report to cover progress against each of the seven elements of the SDMP. This year we are in the progress of reviewing our SDMP with a view to revising it in line with the NHS Long Term Plan 2025 requirements. This commits NHS trusts to 2025 Climate Change Act targets of 51% reduction in carbon emissions, as well as including targets around travel and air pollution.

Over 2019-20 our key priorities will be to:

- publish an updated SDMP to reflect these requirements oversee delivery of this SDMP through our sustainability steering group and report to Board regularly through a set of sustainability KPIs

Buildings: providing the workspace for low carbon care delivery with wellbeing in mind. 2020 target: 34% reduction on

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.

CO2e from our buildings.

Our progress:

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 24% between 2014-15 and 2018-19 (2,240 tonnes CO2e in total). Key highlights and projects for the year ahead include:

- successfully progressing our STP-wide EPC project and aiming to appoint a contractor towards the end of 2019-20 moving to a new utilities management database to improve operational energy management and emissions reporting
- securing £500,000 in funding for new LED lighting from the Department of Health
- a key project for 2019-20 will be to update our carbon targets to 2025 in line with

the NHS Long Term Plan commitment of 51% reduction by 2025

The Trust moved onto a renewable electricity contract on the 1 April 2018 and we are currently investigating a better way to reflect this in our reporting of emissions associated with electricity. As a result of this procurement decision emissions from our consumption when using contract-specific emissions factors was 0 tonnes CO2e, whilst when applying the grid factor they were 3,469 tonnes of CO2e.

Journeys:
maximising the health benefits of our travel and transport activity whilst minimising environmental impacts.
2020 target: 34% reduction in all measurable travel CO2e.

Our progress:
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 2019-20 our specific areas of interest are:

- developing a business case for investment in electric vehicle charging points for staff, reintroducing the cycle to work scheme and introducing car sharing.
- working with STP partners to implement most relevant recommendations from the Courier Services Review
- developing our approach to sustainable travel and set targets to cut the mileage associated with delivery of our services in line with NHS Long Term Plan requirements
- developing measurement and reporting processes to track progress against our Travel Plan targets

Circular economy:
creating and supporting an ethical and resource efficient supply chain.

2020 target:
engage suppliers in reducing impact on the environment

Our progress:
We've made significant progress this year towards our targets of zero waste to landfill and 75% recycling – as well as moving towards taking a broader approach to procurement and circular economy. In particular:

- increasing our offensive waste by 60% since 2017-18 (reducing use of clinical waste)
- we no longer send any domestic waste to landfill, all of the general waste we generate is now disposed of via an energy from waste plant, which generates electricity and road aggregate
- working with local NHS partners to successfully delivery a joint waste tender. New contractors are now in place, saving the trust money and introducing KPIs to support the delivery of this SDMP achieving zero waste to landfill across all our waste streams, including implementation of a new scheme this year diverting all of our offensive waste to a local energy from waste plant. This has cut our waste to landfill, saved the Trust money and reduced the environmental impact of the waste through cutting the emissions associated with waste collections reviewing the options for implementation of reusable sharps next year, as well as a food waste stream next year we will be working with our procurement department to develop our approach to circular economy in more detail

Culture:
informing, empowering and

Our environment

motivating people to take ownership of sustainable healthcare.

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

Our progress:
After an initial piece of work to establish staff views on sustainable healthcare we launched Dare to Care, an ongoing staff engagement programme to support delivery of CWC. The programme allows staff to take an active part in creating a more sustainable healthcare service.

Dare to Care launched in November 2018 with a selection of 11 dares (a dare is a small pledge to do something differently) focused on reducing our impact on the environment, and improving wellbeing. A key aspect of our engagement methodology is to link healthy behaviours with sustainable behaviours, an approach tried and tested by SCFT over the past four years. To date 445 dares have been taken by 81 staff. Our aim is to have 500 dares by November 2019.

Wellbeing:
creating a better working life for our people.
2020 target: reduce sickness rate to 3.5%, 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.

Our progress:
Through the Dare to Care engagement programme we have introduced several dares that have a wellbeing focus, including 'take a walk' and 'drink every drop'. These dares have the benefit of improving wellbeing, but also of reducing our impact on the environment.
In January/February 2019 we launched the 'Step Up Challenge', inviting staff to walk a virtual route over 12 weeks which supports 10,000 steps per day. The challenge ran across 3 trusts enabling us to benchmark against other NHS organisations. Results are still being processed at the time of going to print.

Future:
supporting a strong local health economy to serve our economy now and in the future
2020 target: annual climate change adaptation assessment undertaken as routine component of resilience and business continuity procedures.

Our progress:
Working with our STP partners to develop joint sustainability projects to support our own Trust sustainability goals, and to broaden our impact across the region by working together.

Projects include:
- STP-wide joint EPC procurement, working with the Carbon and Energy Fund to support carbon and cost savings across the STP system through energy improvements
- Joint waste procurement with four local NHS trusts, working with new contractors to deliver against stringent new KPIs

For 2019-20 our priority will to further develop our work around climate change adaptation, in particular through an STP wide climate change risk assessment to understand the impact climate change will have on our buildings and delivery of our services.

Our governance and assurance

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

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.

Members of the Board and additional Directors also meet for Board development seminars on a regular basis.

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 2018-19 are:

Richard Shaw, chair (from 01.11.18) chair of safety and quality committee (until 30.11.18)

- Governor of Brooklands College of Further Education

Alan McCarthy, chair (until 30.09.18)

- 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 interim chair (from 01.10.18 – 31.10.18)

- Magistrate (Justice of the Peace) on Surrey Bench

Paul Biddle, chair of audit and assurance committee

- Non-executive director W&J Linney Ltd
- 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, chair of charitable funds committee and chair of safety and quality committee from 01.01.19)

- Councillor Tandridge District Council (until October 2017)
- Member Consumer Council for Water
- Member Fairchildes Academy Community Trust

David Sadler, chair of finance and workforce committee

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

Daphnee Pushparajah, (Associate non-voting until 30.11.18)

- 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
- Chair South East Coast Regional Talent Board
- 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

Paul Simpson, chief finance officer and deputy chief executive

- Interim Chair of NHS STP Finance Group
- Trustee of Gamble Aware

Dr Ed Cetti, medical director (from 01.01.19)

- No declarations

Dr Des Holden, medical director (until 31.12.19)

- 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

Jane Dickson, chief nurse (from 01.04.18)

- Director of Mull Moments Ltd

Fiona Allsop, chief nurse (until 01.04.18)

- 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

- Member of Hillingdon Hospital NHS Foundation Trust

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

- No declarations

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

- Member of Frimley Health NHS Foundation Trust
- Member of Royal Surrey County NHS Foundation Trust
- Member of Surrey and Borders NHS Foundation Trust

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 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 assist the Board of Directors in exercising its governance in delivering one of the Trusts five strategic objectives, namely Well Led. The following areas are the constituent parts of the Well Led objective within the remit of the Committee: finance and use of resources; workforce; estates; IT; productivity and procurement. The Committee will review five processes of Well Led, namely: assurance; performance; planning; strategy preparation and implementation and investment decisions.

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.

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

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

Signed:

Michael Wilson CBE
Chief executive

Date: 29th May 2019

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 Richard Shaw (from 01.11.18) Richard Durban (01.10.18 until 31.10.18) Alan McCarthy (until 30.09.18)	Chair Caroline Warner (from 01.01.19) Richard Shaw (until 31.11.18)	Chair David Sadler	Chair Caroline Warner
Members* David Sadler (from 01.10.18) (Caroline Warner from 01.11.18) Richard Durban (until 30.09.18) Richard Shaw (until 01.11.18) 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 (until 30.09.18) Pauline Lambert Caroline Warner (until 31.12.18) Richard Durban (from 01.10.18) Chief nurse Medical director Chief operating officer Chief finance officer Clinical chiefs	Members* Paul Biddle David Sadler Richard Durban Daphnee Pushparajah (until 31.11.18) Chief finance officer Director of people and organisational development Director of information and facilities Director of corporate affairs Chief nurse Chief operating officer	Members* Pauline Lambert Paul Biddle Chief finance officer Chief nurse Director of corporate affairs Director of information and facilities

Annual governance statement 2018-19

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.
In preparing this statement I have ensured that it meets the requirements of the model annual governance statement.

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 2019 and up to the date of approval of the annual report and accounts.

3.1 Capacity to handle risk

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 Specific strategic and operational risks

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 2019, end of financial year, BAF identifies no red rated significant risks to the Trust meeting its strategic objectives.

The BAF is a public document available on the Trust website and details 13 strategic risks to the Trust's objectives. 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 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.

Risk title	Current rating	Target rating
Risk of not achieving Waste Reduction Programme	15	6
RTT Access Standards	15	6
Risk of potential overspending from operational pressures	15	9
Risk of Contract income below plan	15	10
Health record systems potential to prevent avoidable harm*	15	12
Risk to the delivery of the elective income plan due to theatre closures	15	9
Financial risk to Medicine divisional year end position	15	6
Due to seasonal peaks in acuity the demand for paediatric HDU care is exceeding capacity and resources	15	6

(*Note: This risk item refers to slippage in the Trust's plans to implement an electronic patient record)

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.

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

4.1 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, e.g. appraisal, alcohol use/abuse policies, professional counselling and occupational health services. The Trust has also appointed a Freedom to Speak Up Guardian who is supported by a number of Freedom to Speak Up Ambassadors.

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

4.2 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.

4.3 Data quality, elective waiting time and Cancer 62 day access standards

Assurance of elective waiting time data is provided though 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
- Elective waiting times included in the internal audit programme

The internal audit programme in 2018-19 looked at RTT 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. Well Led

The Trust is currently rated as Outstanding overall by the CCQ this includes Outstanding ratings for Well Led and the Use of Resources domain.
In an inspection carried out on 16 and 17 October, SASH was

rated outstanding overall by the Care Quality Commission (CQC) Chief Inspector of Hospitals. The Trust was also subject to an inspection of both the 'Well Led' domain on 13th to 14th November 2018 as well as Use of Resources assessment carried out by NHS Improvement. Both these inspections also culminated in the Trust being rated as outstanding. (See the CQC section of the annual report).

PwC conducted a Well-Led Framework Governance Review at SASH in July and August 2018. This is part of the requirement of the NHSI and CQC Well-Led framework which will align to the forthcoming CQC review of the Well-Led Domain later in the year. The report confirms that SASH is a Well-Led organisation. The assessment and RAG rating by PwC for each of the Key Lines of Enquiry (KLOE) mirrors that of the Trust' self-assessment; (seven green and one amber/ green).

There were recommendations included in both of these reports which focus on opportunities to further develop our current governance processes, the Trust has developed action plans to implement these improvements.

5.1 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 4 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; and
- 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:

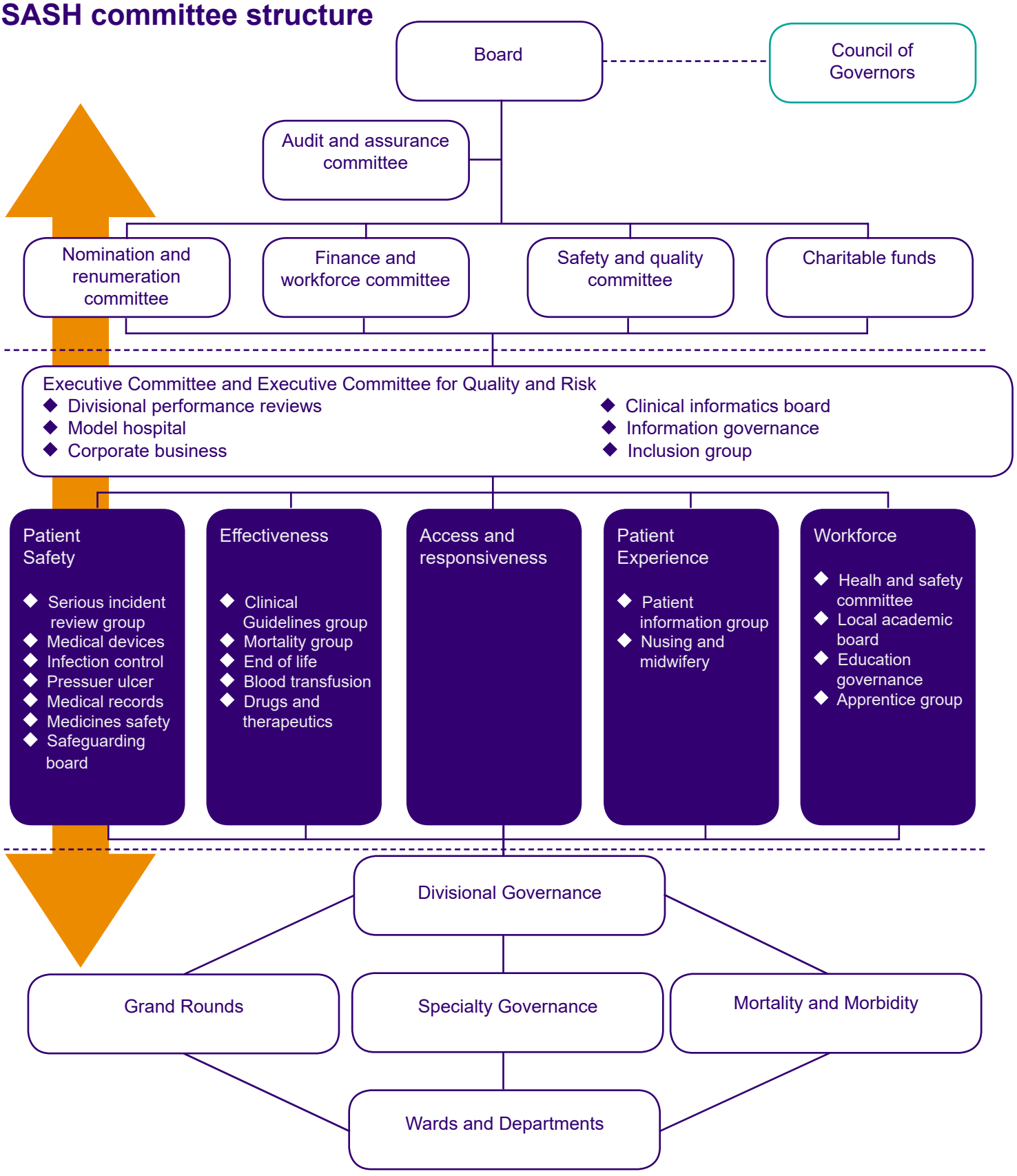
1. **ward/operational reporting to Board relevant issues**
2. **the Board disseminating its strategy and objectives to the wards and operational services**

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.

Accountability

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

SASH committee structure



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.

The Audit and Assurance Committee receive regular review audit reports conducted by Internal Audit. The majority of which provide good or substantial assurance. During the year an audit of the stock management in cardiology produced a no assurance red audit. The issue was unique to the cardiology service. This has been reviewed in detail by the Audit and Assurance Committee who are content with the remedial actions that have been taken to improve control. This has been reported to Board and follow up audits are planned by Internal Audit to review management assurances.

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

The Trust has delivered an £11.2 million surplus in 2018-19, and has reported a £1.3m underlying surplus. This is the third 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 (£2,903 per WAU) nationally. The Trust's liquidity continues to improve with significant loan repayments being made in 2018/19. Improvements in working capital now provides a positive liquidity ratio for the Trust.

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 are updated annually.

The Audit and Assurance Committee reviews management opinion of internal controls systems for resource management (and did so during 2018-19, 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 2018-19 external audit report will be received after this AGS is written, but in the 2017-18 audit, auditors gave the Trust an unconditional value for money conclusion on 25 May 2018. 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.

In January 2019 the Trust was rated "outstanding" for its Use of Resources as part of the NHSi/CQC inspection report and assessment.

5.3 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+ along with four other Trusts SASH have been working in partnership with the Virginia Mason Institute (VMI) in Seattle, USA who has 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.

By focussing 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 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 expand into medical specialties. 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.

5.4 Workforce

The Trust has a board approved workforce strategy, (approved in July 2018), which details our plans to ensures that the right staff, with the rights skills are in the right place at the right time.

The strategy is based on six key themes which ensures short, medium and long-term planning is undertaken to deliver safe, sustainable and effective staffing levels and provide the highest quality of care to our patients.

Progress against the plan is reported to the board monthly through the board assurance framework and through regular reports from the executive team to the NED led Finance and Workforce Committee. Our workforce plans are evidenced based, benchmarked against the Model Hospital, directly linked to other Trust strategies and are supported by relevant education and training activities as required, including the development of new roles. We have implemented an effective recruitment and retention plan and have initiated plans to reduce agency spend, whilst growing our own bank. We use our SASH+ methodology

to support lean working and transformation and we have business continuity plans in place to support unplanned workforce challenges.

The Trust is involved in national and local initiatives to support and develop our workforce, (e.g. the NHSi Retention programme, Best Place to Work), and we take assurance from regular feedback from staff and other internal and external stakeholders. We aspire to be the local employer of choice and the best place to work.

We have undertaken significant consultation with our staff during the past financial year and we are developing action plans to address key issues that have been raised. As part of our recent CQC inspection, (October 2018), as well as the overall Trust being rated as Outstanding, we also received an Outstanding rating for our use of resources.

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

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

5.5 Conflicts of Interest

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

5.6 Sustainability

The Trust has a Sustainable Development Management Plan in place which meets the requirements of the Climate Change Act (2008) and the legally binding carbon reduction targets which it sets out for the UK. These targets are also reflected in the NHS Long Term Plan. The Trust ensures that its statutory obligations relating to environmental legislation are complied with including associated reporting. The Trust is working in partnership with Sussex Community NHS Foundation Trust to deliver Care Without Carbon, our vision for sustainable healthcare which sets out actions to drive improvements and mitigate the risks associated with climate change.

5.7 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 the Trust's compliance is measured according to the indicators in the Data Security Protection toolkit. The Trust submitted its assessment on 28 March 2019 and all mandatory standards have been met. 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 data security risks are added to the Trust risk register and reported in line with the Trust Risk Management Policy. The Trust has not identified any data security Serious Incidents during the financial year.

There are processes in place for incident reporting and investigation of serious incidents. During 2018-19 all reported data security incidents were of minor significance.

The Trust has taken the necessary action to support the implementation of the General Data Protection Regulations from May 2018.

6. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, the Safety and Quality Committee and Finance and Workforce Committee 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.

- As described above I take significant external assurance from both the result of CQC inspection of Trust and external Well Led review during 2018-19.
- 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 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, 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

Accountability

Dr Martin Dachsel, acute medicine consultant

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.

6.1 Significant control issues

There are elements of performance against national constitutional standards that were not achieved in year. The most notable being the emergency department four hour standard, 62 Day Cancer standard and referral to treatment standards. Our performance is detailed in the Performance section of the annual report.

The Trust is actively working internally and with its partners to ensure safety of services and regularly reviews all RTT and Cancer standard breaches to identify any incidence of harm. There has been significant focus on the delivery of ED performance with developments of infrastructure and pathways which have seen the Trust's ED performance rank amongst the highest in the country.

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.

7. Conclusion

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. Noting the significant control areas that I have outlined above relating to the delivery of constitutional standards.

Signed

Michael Wilson CBE
Chief Executive

Date: 29 May 2019

Remuneration and staff report including payroll statement

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 2019 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.

The following sections are subject to audit.

Salaries and allowances 2018-19							
Name	**Title**	**(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							
Cetti Edward	Medical Director	20-25			0-5	25-27.5	50-55
Dickson Jane	Chief Nurse	115-120	1			247.5-250	365-370
Francis-Musanu, Mrs. Gillian Josephine	Director of Corporate Affairs	95-100				52.5-55	150-155
Holden, Mr Desmond Philip	Medical Director	100-105			10-15	0	115-120
Mackenzie, Mr Ian Duncan	Director of Information and Facilities	105-110				0	105-110
Preston, Mr Mark	Director of Organisation Development and People	110-115				30-32.5	145-150
Simpson, Mr. Paul Fraser	Chief Financial Officer	140-145		5-10		35-37.5	190-195
Stevenson, Mrs Angela	Chief Operating Officer	130-135	1			67.5-70	195-200
Wilson, Mr. Michael Anthony	Chief Executive	195-200	1			0	195-200
Non-Executive Directors							
Biddle, Mr. Paul	Non-Executive Director	5-10	3				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	15-20	3				15-20
Sadler, Mr. David	Non-Executive Director	5-10	1				5-10
Shaw, Mr. Richard Oliver	Chairman	15-20	2				15-20
Warner, Mrs. Caroline	Non-Executive Director	5-10	2				5-10

	Band of Highest Paid Director's Total Remuneration (£'000)	**195-200**
	Mid Point of the Banded Total Remuneration of Highest Paid Director (£'000)	**£197,500**
	Median Total Remuneration	**£26,220**
	Ratio	**7.53**

Salaries and allowances 2017-18							
Name	**Title**	**(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							
Cetti Edward	Medical Director						
Dickson Jane	Chief Nurse						
Francis-Musanu, Mrs. Gillian Josephine	Director of Corporate Affairs	**90-95				32.5-35	125-130
Holden, Mr 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	Chairman	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**	Notes * In the salary figure there is a payment of £5,000.01 that relates to 16/17 pension adjustments amended in 2017/18 ** 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 amended in 2017/18
	Mid Point of the Banded Total Remuneration of Highest Paid Director (£'000)	**£202,500**	
	Median Total Remuneration	**£25,551**	
	Ratio	**7.93**	

Pension benefits 2018-19										
Name	Title	(a) Real Increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total Accrued Pension at pension age at 31 March 2019 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5000) £000	(e) Cash Equivalent Transfer Value at 1 April 2017 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2019 £000	(h) Employer's contribution to stakeholder pension £000	(i) Total pension entitlem ent at 31 March 2019 (bands of £5,000) £000
Cetti, Edward	Medical Director	0-2.5	0	30-35	65-70	403	15	447	0	30-35
Jane Dickson	Chief Nurse	10-12.5	32.5-35	40-45	130-135	618	299	934	0	40-45
Stevenson, Mrs Angela	Chief Operating Officer	2.5-5	2.5-5	50-55	125-130	758	147	924	0	50-55
Francis-Musanu Mrs Gillian Josephine	Director of Corporate Affairs	2.5-5	2.5-5	35-40	115-120	746	120	879	0	35-40
Mackenzie, Mr Ian Duncan	Director of Information and Facilities	0	0	40-45	130-135	952	76	1,042	0	40-45
Simpson, Mr. Paul Fraser	Chief Financial Officer	0-2.5	5-7.5	30-35	90-95	618	95	735	0	30-35
Preston, Mr Mark	Director of Organisational Development and People	0-2.5	2.5-5	30-35	75-80	540	87	644	0	30-35

NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury) 2018	1.03	3.00%

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 2018-19 is £195,000-£200,000. This approximates to 7.53 (2017-18 7.93 times) times the median remuneration of the workforce, which is £26,220 (2017-18 £25,551).

The Number of Employees based on the average number of WTE (whole time equivalent including temporary staff) at the trust rose from 4,161 in 2017-18 to 4,376 in 2018-19.

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.

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

	2018/19 total £000	2018/19 permanently employed £000	2018/19 other total £000	2017/18 total £000	2017/18 permanently employed £000	2017/18 other total £000
Salaries and wages	160,455	137,849	22,606	149,105	134,979	14,126
Social security costs	16,059	14,233	1,826	15,380	14,195	1,185
Apprenticship levy	778	778	0	731	731	
Pension cost - employer contributions to NHS pension scheme	18,333	18,333	0	15,785	15,785	
Temporary staff - agency/contracts staff	19,269	0	19,269	17,656		17,656
Total gross staff costs	214,894	171,193	43,701	198,657	165,690	32,967
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(2,831)	(2,831)	0	(712)	(712)	
Total staff costs	212,063	168,362	43,701	197,945	164,978	32,967

Included within:	2018/19 total £000	2018/19 permanently employed £000	2018/19 other total £000	2018/19 total £000	2018/19 permanently employed £000	2018/19 other total £000
Costs capitalised as part of assets	350	172	178	250	250	
Operating expenditure analysed as:						
Employee expenses - staff and executive directors	210,099	166,576	43,523	196,865	163,898	32,967
Research and develoment	588	588	0	558	558	
Education and training	1,026	1,026	0	272	272	
Total employee benefits excl. capitalised costs	212,063	168,362	43,701	197,945	164,978	32,967

Staff numbers and costs

Average Staff Numbers	Total 2018/19 No.	Permanently 2018/19 No.	Other 2018/19 No.	Total 2017/18 No.	Permanent 2017/18 No.	Other 2017/18 No.
Medical and dental	615	562	89	612	565	47
Ambulance staff	0	0	0	0		
Administration and estates	879	767	112	838	721	117
Healthcare assistants and other support staff	920	796	124	889	769	120
Nursing, midwifery and health visiting staff	1,418	1,121	297	1,333	1,051	282
Nursing, midwifery and health visiting learners	0	0	0	0		
Scientific, therapeutic and technical staff	424	384	40	405	374	31
Social Care Staff	0	0	0	0		
Healthcare Science Staff	84	84	0	84		
Other	0	0	0	0		
TOTAL	4,376	3,714	662	4,161	3,564	597
Of which: Number of employees (WTE) engaged on capital projects	5	3	2	4	4	

Early retirements due to ill health

No of early retirements on the grounds of ill health	2018/19	2018/19	2017/18	2017/18
	£000	No 2	£000	No 2
	195		101	

Staff sickness absence

	2018/19 No.	2017/18 No.
Total days lost	29,428	27,219
Total staff years	3,723	3,752
Average working days lost (per WTE)	8	7

Reporting of other compensation schemes - exit packages 2018-19

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2018/19 No.	Cost of compulsory redundancies 2018/19 £000	Number of other departures agreed 2018/19 No.	Cost of other departures agreed 2018/19 £000	Total number of exit packages 2018/19 No.	Total cost of exit packages 2018/19 £000	Number of departures where special payments have been made 2018/19 No.	Cost of special payment element included in exit packages 2018/19 £000	Compulsory redundancies average cost £000	Other departures average cost £000
Less than £10,000			1	10	1	10				10
£10,000 - £25,000					0	0				
£25,001 - £50,000					0	0				
£50,001 - £100,000					0	0				
£100,001 - £150,000					0	0				
£150,001 - £200,000					0	0				
>£200,000					0	0				
Total			1	10	1	10	0	0	0	0

Reporting of other compensation schemes - exit packages 2017-18

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2017/18 No.	Cost of compulsory redundancies 2017/18 £000	Number of other departures agreed 2017/18 No.	Cost of other departures agreed 2017/18 £000	Total number of exit packages 2017/18 No.	Total cost of exit packages 2017/18 £000	Number of departures where special payments have been made 2017/18 No.	Cost of special payment element included in exit packages 2017/18 £000	Compulsory redundancies average cost £000	Other departures average cost £000
Less than £10,000					0	0				
£10,000 - £25,000					0	0				
£25,001 - £50,000					0	0				
£50,001 - £100,000			1	51	1	51				51
£100,001 - £150,000					0	0				
£150,001 - £200,000					0	0				
>£200,000					0	0				
Total	0	0	1	51	1	51	0	0		51

Exit packages: other non compulsory departure payment

	Payments agreed 2018/19	Total value of agreements 2018/19	Payments agreed 2018/19	Total value of agreements 2018/19
	No.	£000	No.	£000
Voluntary redundancies including early retirement contractual costs				
Mutually adreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice				
Exit payments following employment tribunals of court orders	1	10	1	51
Non contractual payments requiring HMT approval (special severance payments)*				
Total	1	10	1	51

Conclusion

Stay in touch

Surrey and Sussex Healthcare NHS Trust

Trust Headquarters Canada Avenue Redhill
Surrey RH1 5RH
01737 768511

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)
sash.pals@nhs.net
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, la
rge print and braille. For further information please contact PALS (Patient Advisory Liaison Service) on 01737 231958 or email: sash.pals@nhs.net

Finances

The year in context

The Trust ended 2018-19 with a surplus of £11.2m (after technical adjustments). In the current climate this is a notable achievement, allowing the Trust to invest in additional capital works during the year and to significantly improve it working capital position.

In January 2019 the Trust was also rated "Outstanding" for Use of Resources by NHS Improvement and the CQC, in addition to being rated "Outstanding" in respect of Quality.

In summary, the Trust:

- ✓ Has delivered a financial surplus for the third consecutive financial year;
- ✓ Achieved £4.8m of savings (meeting its planned savings target);
- ✓ Received £9.9m of non-recurrent Provider Sustainability Funding (PSF) from NHS Improvement. Excluding this non-recurrent funding the Trusthad a £1.3m underlying surplus position.
- ✓ Significantly improved its working capital position.
- ✓ Stayed within its External Financing Limit (EFL).
- ✓ Stayed within its Capital Resource Limit (CRL), with a capital spend of £18.0m
- ✓ Delivered its Better Payment Practice Code (BPPC) target of 95% of bills paid within 30 days (the first time the Trust has achieved that)

The Trust was not able to fully achieve the £16.1m surplus financial control total assigned to it by NHS Improvement, and consequently agreed a revised forecast outturn during the 2018-19 financial year of £7.3m. The surplus delivered matches the final expected position plus a further £3.9m of Provider Sustainability Funding awarded to the Trust by NHS Improvement and notified on 18 April 2019.

The cost per weighted activity unit (WAU) is a unit cost measure introduced as part of Lord Carter's and NHS Improvement's Operational Productivity work and recorded in the "Model Hospital" data portal. The Trust's 2017-18 (most recent numbers) cost per WAU is the lowest for any acute trust nationally (£2,903 per WAU). Our 2017-18 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 2016-17 and describe strong value for money. The Trust's 2018-19 reference cost index and WAC will be notified to the Trust in the later part of 2019.

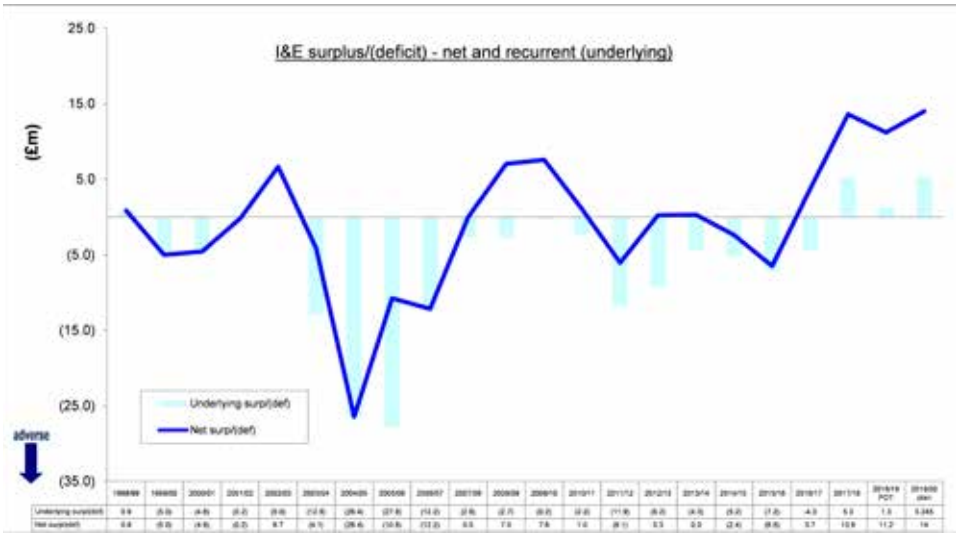
This performance is against a context of significant deficits in acute trusts across the country, and continued activity pressure nationally and locally. For the Trust, emergency attendances rose, again, to their highest ever levels in 2018-19. Although the Trust's new internal pathways (introduced with the help of commissioners, and now including an ambulatory care unit - Kingsfold) helped to constrain the number of emergency admissions to Trust beds we still did not have sufficient bed capacity to treat the expected level of planned care (elective) patients referred to us.

Local Clinical Commissioning Groups (CCGs), who formed the Sussex and East Surrey Alliance during the year (taking in East Sussex CCGs and Coastal West Sussex) again agreed an end year financial settlement that provided certainty in year and a fair final position for both organisations.

Within that settlement CCGs have provided a one-off payment that partially covered the impact of part of the cost of emergency admissions (there is a "Marginal Rate Emergency Tariff" [MRET] which otherwise

reduces the payment the Trust gets to 70% of the tariff for the number of patients above 2008 levels). The compromise over the MRET settlement was the main driver behind not delivering the original control total, and the subsequent loss of £3.2m of Provider Sustainability Funding (PSF).

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 £14.0m surplus planned for 2019-20 (to meet the control total assigned to the Trust by NHS Improvement) includes £6.6m non-recurrent PSF.



Trust financial performance from its creation in 1998-99 (see graph above right).

Use of Resources: inspected and rated "outstanding"

The Use of Resources rating for the Trust is completed by NHS Improvement and published by the CQC alongside their other trust-level ratings. All six trust-level ratings for the Trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the trust's combined rating, which, overall was also Outstanding.

This Trust, at the time of drafting this annual report, is one of only half a dozen in the country rated outstanding for Use of Resources. The full report can be accessed via the CQC website (https://www.cqc.org.uk/provider/RTP) and its summary includes the following points:

a Using 2017-18 data the Trust has the lowest total cost per Weighted Activity Unit (WAU) in the country and performs well across the specific "Use of Resources" Model Hospital metrics. Please see "Reference costs and cost per weighted activity unit" section later - the Trust also performs well generally across most aspects covered by the Model Hospital portal;

b There is visible evidence of a clear commitment to continuously improve productivity and quality of care, particularly through the Trust wide SASH+ programme (referred to elsewhere in this annual report);

c Use of resources is about how an organisation operates, and the Trust performs strongly on clinical services, outperforming most trusts in England for the delivery of constitutional standards. The Trust also benchmarks well against several clinical services metrics linked to efficiency such as pre-procedure bed days (preparation prior to operations) and readmissions (we have a very low proportion of people having to come back to hospital after a procedure) and has seen improvement in others such as Delayed Transfer of Care (DTOC) and Did Not Attend (DNA) rates to better or near the national median;

d The Trust benchmarks well on its efficiency measures for pathology, imaging and pharmacy services and corporate services (Finance, Human Resources [Organisational Development and People], Information Management and Technology)

compared to other trusts;

e The Trust has delivered surpluses in recent years and has improved its liquidity position to the point where it now has good cash balances allowing it to repay past debt;

f The Trust can evidence how it uses information from the Model Hospital, the Getting It Right First Time (GIRFT) programme (we have a "Model Hospital Group" chaired by the CEO) and other initiatives to drive service improvement and productivity gains alongside the SASH+ programme;

The report did identify areas for improvement, and the report noted that spend on agency staff remains high (including as a proportion to the total pay bill), there are delays in the delivery of anticipated savings of the pathology network the Trust is part of due to configuration issues and there are opportunities to improve productivity on procurement.

Reference costs and cost per weighted activity unit
The 2017-18 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 2017-18 figure at just under 83 (rounding masks the improvement). 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 that can be compared with the average unit cost across the country. The Trust has a cost per weighted activity unit of £2,903, the lowest unit cost in England for an acute trust.

(See above right, Trust priductivity metrics).

	Reference cost index	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	
2015/16	86	£3,010
2016/17	83	£2,930
2017/18	83	£2,903

Conclusion

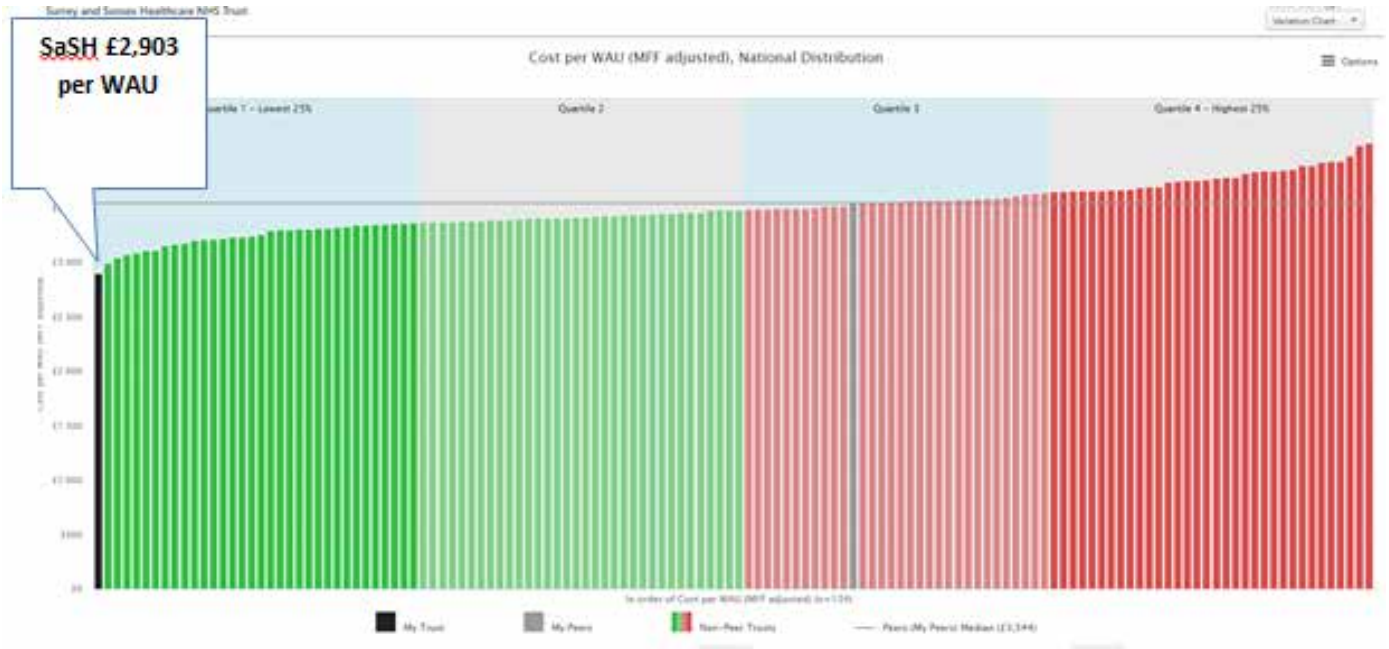


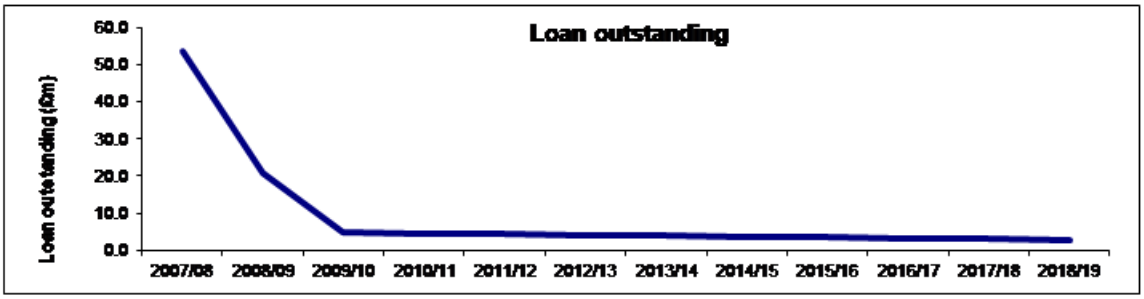
Chart shows ranking position for all trusts with data reported in thte Model Hospital - colour bandings reflect quartile - darker green (left) is the best quartile and daker red (right is the worst quartile)

The original loan and the statutory breakeven duty

Surrey and Sussex Healthcare NHS Trust secured its £56.0m working capital loan at the end of 2006-07 to cover debts from its poor financial performance up to that time.

The current position on the loan is described below, with £2.8m left outstanding. The Trust is now making the scheduled payments required by its 25year loan agreement against that balance.

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)	2018/19 (£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)	(3.0)
Conversion to PDC		26.0	8.8									
Trust repayment	2.2	7.0	7.9	0.3	0.2	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)	(2.8)



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 (maximum) 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 issue another letter advising anything further on this matter.

NHS Improvement issued guidance in respect of the breakeven duty in April 2018 and the format of reporting changed in last year's the accounts (at note 52), with the start point being changed to 2009-10. This is because 2009-10 was the first year of International Financial Reporting Standards (IFRS) implementation and NHS Improvement, apparently, regard that as a more suitable point from which the breakeven duty should now be assessed.

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 2018-19 that stands at £3.0m.

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 £56.0m one above) has now been largely paid off but will remain in place as the Trust moves into 2019-20 as 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 £6.2m left to repay (in total) on these loans at 31 March 2019.

Looking forward – sustainability: financial strategy overview

Last year (in 2018-19) the Trust delivered on its previous short term financial strategy objectives (which were: "stabilising the Trust's clinical services in the face of increasing emergency demand to provide sufficient capacity to deliver clinical and financial plans", and; "recover the normalised [financial] position").

For 2019-20 onwards we have reviewed our strategy and updated it, and also to recognise the requirements of the NHS Long Term Plan.

The refreshed financial strategy is as follows:

- Build on the recurrent surplus achieved in 2018-19 and sustain recurrent balance;
- use non-recurrent sustainability funding to replenish the balance sheet and maintain a positive cash balance;
- cover the costs of activity demand while striving for greater productivity and efficiency;
- agree financial

Conclusion

mechanisms with CCGs that support pathway and model of care changes, and do whatever the Trust can (without jeopardising the items above) to support local CCG financial positions.

- become part of a financially sustainable integrated care partnership with other local providers that delivers continuous operational efficiency, improves health outcomes and works in fuller and more effective partnership with other local stakeholders;

The financial plan connection to the operational plan

The financial plan is supported by an operational plan (and vice versa), describing how the Trust delivers its access and clinical standards. A key component in that is about managing emergency demand and maintaining capacity to do elective work. Although simplistic, this aspect has a widespread (direct and indirect) impact on how the Trust performs financially. Too much emergency activity does not fit into the capacity and requires additional resource to manage it while disrupting a wide range of other services which restricts elective income while we still have fixed costs to service and we have to do additional work (at extra cost) to ensure the elective referral to treatment standards are met.

The operational plan saw additional capacity for elective activity created in 2015-16 (an additional elective ward, an additional theatre, and additional day case capacity) and we opened the Surgery Day Unit at East Surrey Hospital at the end of summer 2017-18 (reproviding our day case capacity). However, initially the growth in emergency demand continued to prevent the effective use of this capacity, requiring us to implement further significant infrastructure and significant changes to the model of care for people that would otherwise be visiting the emergency department.

In October 2017-18 Kingsfold opened as an ambulatory care unit (a very different model of care for emergency attendances) and along with the work around the emergency department (including changes to how ambulances queue, and providing a canopy), changes to ways of working in other wards (eg “cohorting” long stay patients on Tandridge) and the introduction of primary care streaming (GP’s in the ED) that has further helped manage emergency activity volumes. This has seen a significant increase in “same day emergency care” treatments and the number of patients admitted that stay longer than a day has started to flatten, despite the very great increase in attendances to the emergency department we have seen. Increasing same day emergency care is a priority in the NHS Long Term plan.

Further to that, in the winter of 2018-19 the Trust opened Horley Ward (built with funding provided by NHS Improvement), which is intended as a “decant” ward in the summer (ie: moving patients into it so that we can close other wards occasionally, eg for refurbishment work) and as extra capacity in the winter.

In 2018-19 theses measures helped provide more capacity for elective work and although the Trust did not quite meet the referral to treatment standard, it halved the number of patients waiting over 52 weeks and reduced its waiting list significantly. Indeed, the performance was better than most other trusts in England.

Of course, the position is very fluid, and the Trust saw serious peaks in ambulance conveyances during January 2019 and there is a long standing problem with very long stay emergency patients (called “super-stranded patients”) whose number has stayed around 120 for much of the year because it is problematic to find them places out of hospital. Dealing with this group of patients provides a central

theme not just for the Trust's operational plan in 2019-20 but also for that of the whole health system.

2019-20 budget

The 2019-20 revenue budget has been constructed to facilitate delivery of the £14.0m I and E control total surplus. The control total has been set by NHS Improvement and the Board confirmed its acceptance in the Trust's Plan submission in April 2019.

The reason for this large surplus target is because the Trust will be paid a £5.2m refund of the previously unpaid marginal rate emergency tariff ("MRET" - which was the subject of the compromise deal with CCGs in 2018-19) and, if it delivers the quarterly financial targets, £6.6m of provider sustainability funding. The underlying surplus the Trust must deliver is £2.2m.

The revenue budget was approved by the Board in March 2019 and includes:

a Receipt of £6.6m provider sustainability funding (PSF);

b Receipt of £5.2m MRET refund and its application directly to the surplus – as this funding should actually be set against the cost of emergency activity this is a saving;

c The combined core Waste Reduction Plan (WRP – savings of £6.0m)) and additional cost reductions by Divisions of £4.0m – total £10.0m – with the MRET the saving required is challenging at about 4.5% of turnover;

d £2.0m financial contingency against cost pressures;

e Expenditure through a "quality reserve" budgeted at £1.0m.

2019-20 Savings and productivity

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

Within the Trust the CEO 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 waste reduction plan, productivity plans and clinical improvement plans.

Chart: Model Hospital Quality, Efficiency, Deficit (QED) chart

This chart (opposite above right) combines multiple metrics to try to give an overall picture of each trust's performance against others.
The position of each trust is plotted by:

- surplus or deficit as a % of operating expenditure (y axis)
- cost per WAU, which represents overall relative productive efficiency (x axis)
- The colour of each bubble reflects the CQC segment for that trust

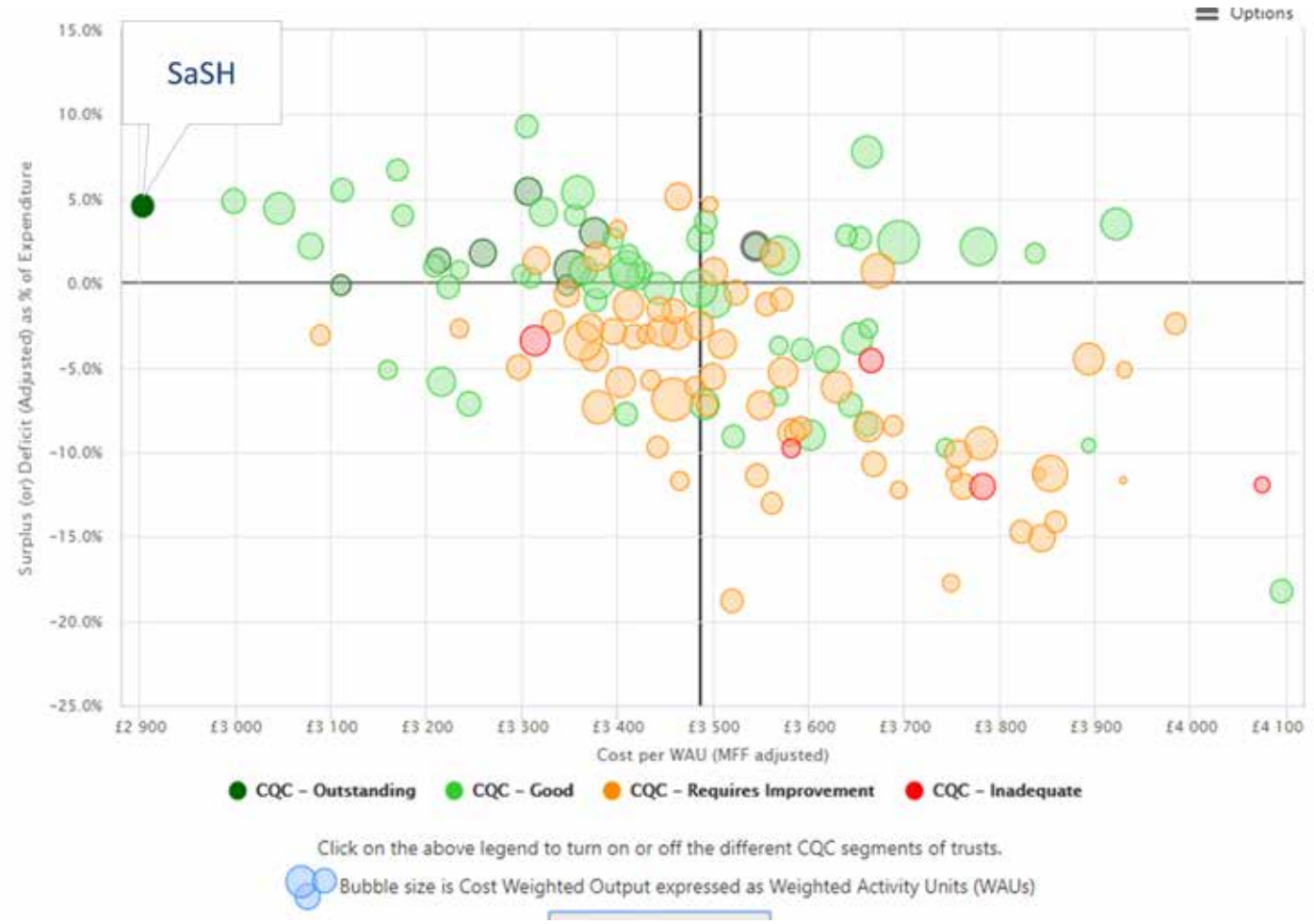
As can be seen in the chart, the Trust ranks very well against others, and the chart also providers a flavour of how other trusts are performing.

In terms of the detail within the Model Hospital, the Trust benchmarks well in the majority of categories (the portal is very extensive [this list is not all exhaustive] but includes data on staff, non-pay, nursing, pathology services, medicines management, back office, estates and facilities, procurement and detail Getting It Right First Time programme information for many clinical specialties).

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

Conclusion



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. In 2019-20 the core waste reduction plan (WRP) is set at £6.0m, with an additional £4.0m to gain from Divisional spend reductions. Add to that the need to deliver a surplus against the £5.2m of MRET funding paid as part of the Control Total regime, and the total cash releasing benefit required is £15.2m, about 4.5% this is a very challenging target.

Waste reduction and cost improvements are modelled to come from all areas of the Trust but major on agency reduction, procurement, usage of consumables, drugs, and additional duty costs. 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 2018-19 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.

Conclusion

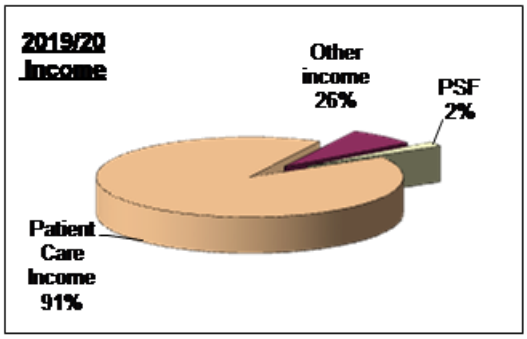
Income & Expenditure: EBITDA Presentation*	2009/10 (£m)	2010/11 (£m)	2011/12 (£m)	2012/13 (£m)	2013/14 (£m)	2014/15 (£m)	2015/16 (£m)	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)
Income from patient care	174.1	179.8	189.3	197.0	210.6	224.8	240.9	258.0	283.9	304.5
Other operating income	20.8	16.4	20.3	29.0	20.8	19.0	24.0	28.4	31.6	31.7
Net operating income	**194.9**	**196.2**	**209.6**	**226.0**	**231.4**	**243.8**	**264.9**	**286.3**	**315.4**	**336.2**
Operating expenses	(178.9)	(187.2)	(207.0)	(215.0)	(220.4)	(234.5)	(258.2)	(268.6)	(286.9)	(309.6)
Operating Surplus/(Deficit) (EBITDA)	**16.0**	**9.0**	**2.6**	**11.0**	**11.0**	**9.3**	**6.7**	**17.7**	**28.6**	**26.5**
Net interest and other items	(0.8)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.5)	(0.4)	(0.8)	(0.5)
Depreciation	(4.5)	(4.7)	(5.4)	(7.3)	(7.2)	(7.8)	(8.7)	(9.2)	(9.4)	(9.6)
PDC dividends payable	(2.9)	(3.0)	(3.0)	(3.1)	(3.2)	(3.6)	(3.9)	(4.4)	(4.7)	(5.3)
NHS performance Surplus/(Deficit)	**7.6**	**1.0**	**(6.1)**	**0.3**	**0.3**	**(2.4)**	**(6.5)**	**3.7**	**13.6**	**11.2**
Impairments/donated assets tech adj		(4.8)	0.0	0.1	0.0	0.0	2.4	(0.2)	(0.0)	(0.0)
NET SURPLUS/ (DEFICIT)	7.6	(3.7)	(6.1)	0.4	0.3	(2.4)	(4.1)	3.4	13.6	11.2
Underlying Surplus/(Deficit)	(0.2)	(2.2)	(13.3)	(9.2)	(4.3)	(5.2)	(7.2)	(7.2)	5.4	1.3
B'even duty: Cumulative deficit	(39.4)	(38.4)	(44.5)	(44.2)	(43.9)	(46.3)	(52.9)	(49.3)	(35.7)	(24.4)

Detail of overall income and expenditure performance since 2009-10.

Income 2019-20 – looking forward

In 2019-20 our income is forecast to total £357.0m, taking into account £6.6m of Provider Sustainability Funding and £5.2m of MRET funding (both paid as part of the sign up to the control total, with the former conditional on performance).

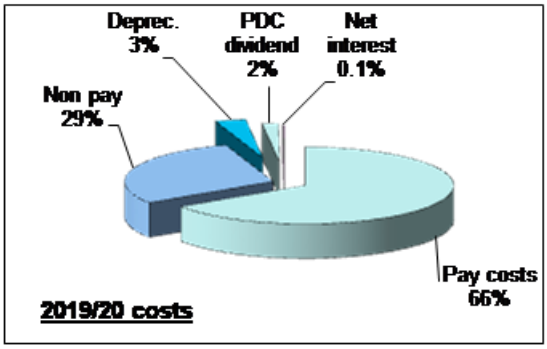
Income:	2019/20 Plan (£m)
Patient Care Income	324.5
Other Operating Income	26.0
Provider sustainability funding	6.6
Total income	357.0



Costs 2019-20 – looking forward

Costs in 2018-19 are forecast to total £343.0m, split as described in the table and chart (bottom right).

Costs	2019/20 Plan (£m)
Operating costs	
Pay costs	225.4
Non pay costs	99.9
Sub total: operating costs	325.3
Depreciation/amortisation	11.4
PDC dividend	6.0
Net interest paid/received	0.4
Total costs	343.0



Conclusion

In 2018-19 the Trust spent £18.0m on capital investment (buildings, IT and equipment) and stayed within our Capital Resource Limit (CRL).

The funding to pay for the programme included a number of additional elements (on top of the core capital resource limit generated from depreciation), as follows:

- £2.5m of capital resource limit awarded in respect of good financial performance in 2017-18;
- £3.9m of NHS Improvement capital for urgent and emergency care services (to pay for Horley Ward);
- £3.2m of capital funded from cash reserves generated from the Trust surplus, and;
- £0.7m provided by the Sussex and East Surrey Sustainability and Transformation Partnership to fund hardware for our electronic patient record.

A wide-range of different projects were delivered in-year, over 100, with the principle focus being investment in estate to improve how the Trust works and improve care for patients. The principal areas of large item spend (>£0.3m) were as follows:

Item	£m
Horley Ward, a decant ward in the summer (moving patients into it so that we can close other wards occasionally, eg for refurbishment work) and as extra capacity in the winter.	4.4
Dental and Obstetrics/ Gynaecology Outpatients (stage 1 of our neo natal build – reproviding for services whose accommodation needed to be altered in the project)	2.8
EPR (electronic patient record - hardware)	1.4
IT other than EPR	0.9
Radiology Equipment	0.5
Backlog Maintenance	1.9

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

Neo-natal unit refurbishment and redesign

The Trust's biggest project is the refurbishment and redesign of the neonatal unit, where we don't have enough space for our cots. That spreads over two years.

A part of that work is well underway [in April 2019] on the Dental and Obstetrics/ Gynaecology outpatients areas that need to be reprovided and this is scheduled to complete at the end of May. The existing outpatient facilities will then move into the new build and work will then commence on the neonatal refurbishment and expansion. This will finish by the end of 2019.

Electronic patient record Digitise

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 in 2017-18, and neither was it forthcoming in 2018-19.

As a result, the Trust is having to split the Digitise project into component parts and match capital to each from whichever sources it can. In 2018-19 we used £0.7m of Trust capital alongside an award of £0.7m of STP funding to buy hardware. As we move into 2019-20 it was hoped that the central funding of electronic prescribing and medicines administration (EPMA) would have been announced by March, but again the award of funding has been postponed. We will continue to review and work through how we manage this important upgrade to our electronic patient record systems.

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Signed:

Michael Wilson CBE
Chief executive

Date: 29th May 2019

Conclusion

Electronic patient records team

Notes

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Produced by the communications team

Surrey And Sussex Healthcare NHS Trust

Annual accounts for the year ended 31 March 2019

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 ("the Trust") financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of the Trust's 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 2018/19.

We have audited the financial statements, included within the Annual Report (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2019; the Statement of Comprehensive Income for the year then ended; the Statement of Cashflows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the accounts, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the Local Audit and Accountability Act 2014, 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 the 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 Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the 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.

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 2018/19 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 2019 is consistent with the financial statements and has been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

In light of the knowledge and understanding of the 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 2018/19.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 60, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, 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 the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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.

We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

Our audit did not consider any impact that the United Kingdom's withdrawal from the European Union may have on the Trust as the terms of withdrawal are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

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 paragraph 24 of Schedule 7 of the National Health Service Act 2006 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 required reporting

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 the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We determined that there were no matters to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- we have referred a matter to the Secretary of State for Health under section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or a director or officer of the 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 Local Audit and Accountability Act 2014.
- we have made written recommendations to the Trust under section 24 of the Local Audit and Accountability Act 2014 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 section 21 of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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

29 May 2019

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.....29/5/2019

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

Signed.....

Michael Wilson CBE
Chief Executive

Date 29/5/2019

Signed.....

Paul Simpson
Chief Finance Officer

Date 29/5/2019

Statement of Comprehensive Income for the Year Ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	304,512	283,866
Other operating income	4	31,657	31,555
Operating expenses	6, 8	(319,192)	(296,302)
Operating surplus/(deficit) from continuing operations		**16,977**	**19,119**
Finance income	11	100	26
Finance expenses	12	(609)	(850)
PDC dividends payable		(5,260)	(4,686)
Net finance costs		**(5,769)**	**(5,510)**
Other gains / (losses)	13	0	0
Surplus / (deficit) for the year from continuing operations		**11,208**	**13,609**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(783)	0
Revaluations	17	2,963	7,897
Total comprehensive income / (expense) for the period		**13,388**	**21,506**

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 for the Year Ended 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	1,952	1,784
Property, plant and equipment	15	191,704	181,253
Trade and other receivables	23	4,216	3,982
Total non-current assets		**197,872**	**187,019**
Current assets			
Inventories	22	4,354	5,063
Trade and other receivables	23	23,742	24,351
Cash and cash equivalents	26	10,145	5,279
Total current assets		**38,241**	**34,693**
Current liabilities			
Trade and other payables	27	(26,573)	(24,793)
Borrowings	30	(2,139)	(2,085)
Provisions	33	(284)	(267)
Other liabilities	29	(2,167)	(1,916)
Total current liabilities		**(31,163)**	**(29,061)**
Total assets less current liabilities		**204,950**	**192,651**
Non-current liabilities			
Trade and other payables	27	(3,106)	(3,212)
Borrowings	30	(19,079)	(24,651)
Provisions	33	(1,753)	(1,840)
Total non-current liabilities		**(23,938)**	**(29,703)**
Total assets employed		**181,012**	**162,948**
Financed by			
Public dividend capital		157,570	152,894
Revaluation reserve		51,542	50,548
Income and expenditure reserve		(28,100)	(40,494)
Total taxpayers' equity		**181,012**	**162,948**

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

Signature .....

Name Michael Wilson CBE

Position Chief Executive Officer

Date 29/5/2019

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**152,894**	**50,548**	**(40,494)**	**162,948**
Surplus/(deficit) for the year	0	0	11,208	**11,208**
reserve for impairments arising from consumption of economic benefits	0	(1,186)	1,186	**0**
Impairments	0	(783)	0	**(783)**
Revaluations	0	2,963	0	**2,963**
Public dividend capital received	4,676	0	0	**4,676**
Taxpayers' equity at 31 March 2019	**157,570**	**51,542**	**(28,100)**	**181,012**

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/(deficit) for the year	0	0	13,609	**13,609**
Revaluations	0	7,897	0	**7,897**
Public dividend capital received	1,045	0	0	**1,045**
Other reserve movements	0	(982)	982	**0**
Taxpayers' equity at 31 March 2018	**152,894**	**50,548**	**(40,494)**	**162,948**

Statement of Cash Flows for the Year Ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		16,977	19,119
Non-cash income and expense:			
Depreciation and amortisation	6.1	9,571	9,441
Income recognised in respect of capital donations	4	(229)	(173)
(Increase) / decrease in receivables and other assets		472	(6,899)
(Increase) / decrease in inventories		709	(584)
Increase / (decrease) in payables and other liabilities		(202)	526
Increase / (decrease) in provisions		(72)	(137)
Net cash generated from / (used in) operating activities		**27,226**	**21,293**
Cash flows from investing activities			
Interest received		100	26
Purchase of intangible assets		(815)	(661)
Purchase of property, plant, equipment and investment property		(14,903)	(11,286)
Receipt of cash donations to purchase capital assets		229	173
Net cash generated from / (used in) investing activities		**(15,389)**	**(11,748)**
Cash flows from financing activities			
Public dividend capital received		4,676	1,045
Movement on loans from the Department of Health and Social Care		(5,262)	(5,092)
Capital element of finance lease rental payments		(395)	(263)
Interest on loans		(497)	(821)
Interest paid on finance lease liabilities		(107)	(54)
PDC dividend (paid) / refunded		(5,386)	(4,656)
Net cash generated from / (used in) financing activities		**(6,971)**	**(9,841)**
Increase / (decrease) in cash and cash equivalents		**4,866**	**(296)**
Cash and cash equivalents at 1 April - brought forward		**5,279**	**5,575**
Cash and cash equivalents at 31 March	26.1	**10,145**	**5,279**

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 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
The Trust made a surplus of £11.2m in 2018/19. The additional positive cashflows associated with this £11.2m 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 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 £11.2m surplus delivered in 2018/19, and the agreement of the amounts payable by the Trust's 11 main CCG commissioners for 2018/19, 2 will mean the Trust will have sufficient cash available to fully repay the remaining £3m revolving capital in 2018/19 and the £5.8m interim revenue support loan in 2019/20. It is the Trust's desire to do this as the amount borrowed attracts annual interest chargesof 3.5% and 1.5% respectively. The Trust is planning in delivering a £14m I & E surplus in 2019/20. Even if this is only partly delivered, as was the case in 2018/19, 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 2019/20 which has been agreed with the NHSi. The financial statements have therefore been prepared on a going concern basis.

Note 1.3 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. There were no particular judgements made in the application of IFRS 15 that significantly affected the determination of the amount or timing of revenue recognised.

Note 1.3.1 Sources of estimation uncertainty
The agreement of Memorandum of Understandings with the Trust's eleven main CCG Commissioners has provided certainty as to the amounts payable to the Trust in respect of clinical income for 2018/19. The income owed by the Trust's other two main Commissioners, NHS England and Croydon CCG have been agreed in respect of prior years. Amounts owed in respect of 2018/19 are based on recorded activity levels at national and local agreed tariff rates. Activity levels and related income are discussed and reconciled with the Trust's commissioners throughout 2018/19 with the aim to reaching consensus as the amounts due to the Trust. This process will carry on after the Trust's 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

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

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 of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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.

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

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

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

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

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

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

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

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

Not applicable to the Trust.

Note 1.7.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	25	55
Plant & machinery	5	15
Transport equipment	5	5
Information technology	5	8
Furniture & fittings	5	13

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., 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, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
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) method.

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 assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement
Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition

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

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

Note 1.14 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 an item of property plant and equipment.

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

Operating leases

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

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

Leases of land and buildings

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

Note 1.14.2 The Trust as lessor

Finance leases

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

Operating leases

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

Note 1.15 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 33.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 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 of 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 determined that it is has no corporation tax liability on the basis that it is solely a public sector body with no limited company subsidiary arm.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

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 2018/19 or 2017/18. Nor have 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 2018/19.

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

The Trust has not applied any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector.

Note 2 Operating Segments

During 2018/19 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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
(Income within this note is recognised in accordance with IFRS 15)	**£000**	**£000**
Elective income	50,267	47,718
Non elective income	123,134	109,883
First outpatient income	35,558	34,070
Follow up outpatient income	17,475	16,549
A & E income	17,060	15,751
High cost drugs income from commissioners (excluding pass-through costs)	14,448	13,932
Other NHS clinical income	39,524	42,955
All services		
Private patient income	319	363
Agenda for Change pay award central funding	3,263	-
Other clinical income	3,464	2,645
Total income from activities	**304,512**	**283,866**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
(Income within this note is recognised in accordance with IFRS 15)	**£000**	**£000**
NHS England	26,346	26,665
Clinical commissioning groups	266,080	248,725
Department of Health and Social Care	3,263	-
Other NHS providers	906	278
NHS other	731	-
Non-NHS: private patients	319	363
Non-NHS: overseas patients (chargeable to patient)	572	552
Injury cost recovery scheme	687	661
Non NHS: other	5,608	6,622
Total income from activities	**304,512**	**283,866**
Of which:		
Related to continuing operations	304,512	283,866

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

	2018/19	2017/18
	£000	£000
Income recognised this year	572	552
Cash payments received in-year	250	207
Amounts added to provision for impairment of receivables	200	404
Amounts written off in-year	102	53

Overseas patient income included within this note of £572k for 2018/19 (£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 is instead categorised as income from Clinical Commissioning Group income. Income covered by reciprocal arrangements amounted to £534k in 2018/19 (£393k in 2017/18). Total income received by the Trust in respect of overseas patients amounted to £1,106k in 2018/19 being the sum of £572k and £534k. (£945k in 2017/18 being the sum of £552k and £393k).

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers (recognised in accordance with IFRS 15):		
Research and development (contract)	591	574
Education and training (excluding notional apprenticeship levy income)	7,198	9,795
Non-patient care services to other bodies	3,755	6,440
Provider sustainability / sustainability and transformation fund income (PSF / STF)	9,922	8,213
Income in respect of employee benefits accounted on a gross basis	2,057	1,140
Other contract income	7,858	5,174
Other non-contract operating income (recognised in accordance with other standards)		
Receipt of capital grants and donations	229	173
Rental revenue from operating leases	47	46
Total other operating income	**31,657**	**31,555**
Of which:		
Related to continuing operations	31,657	31,555

Other contract income relates mainly to income generation activities and includes car parking income (£1,869k), catering (£779k) pharmacy sales (£336k) and crèche services (£601k), as well as other ad-hoc divisional income.

Note 5 Fees and charges

Not relevant for this Trust.

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,690	2,702
Purchase of healthcare from non-NHS and non-DHSC bodies	6,458	5,984
Staff and executive directors costs	210,099	196,865
Remuneration of non-executive directors	77	81
Supplies and services - clinical (excluding drugs costs)	28,600	27,970
Supplies and services - general	5,472	5,334
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	23,083	21,765
Inventories written down	73	27
Consultancy costs	8	8
Establishment	4,457	4,079
Premises	13,851	11,260
Transport (including patient travel)	580	441
Depreciation on property, plant and equipment	8,924	8,641
Amortisation on intangible assets	647	800
Movement in credit loss allowance: contract receivables / contract assets	273	-
Movement in credit loss allowance: all other receivables and investments	0	371
Increase/(decrease) in other provisions	0	97
Change in provisions discount rate(s)	(24)	19
Audit fees payable to the external auditors:		
audit services- statutory audit	78	78
other auditors remuneration (external auditors only)	39	0
Internal audit costs	115	111
Clinical negligence	9,418	6,984
Legal fees	245	383
Insurance	210	221
Research and development	588	558
Education and training	2,368	924
Rentals under operating leases	12	0
Car parking & security	174	155
Hospitality	14	16
Losses, ex gratia & special payments	167	226
Other services, eg external payroll	496	202
Total	**319,192**	**296,302**
Of which:		
Related to continuing operations	319,192	296,302

Note 7 Impairments

Following the 2018/19 revaluation of the Trust land and buildings, £783k was taken to the revaluation reserve as an impairment. There were no impairments charged to revenue in 2018/19.

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	160,455	149,105
Social security costs	16,059	15,380
Apprenticeship levy	778	731
Employer's contributions to NHS pensions	18,333	15,785
Temporary staff (including agency)	19,269	17,656
Total gross staff costs	**214,894**	**198,657**
Recoveries in respect of seconded staff	**(2,831)**	(712)
Total staff costs	**212,063**	**197,945**
Of which		
Costs capitalised as part of assets	350	250

Note 8.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £195k (£101k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 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.

The Trust granted a site lease to A2 Housing Solutions Ltd in 2008-09, for a term of 35 years.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	47	46
Total	**47**	**46**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	47	46
- later than one year and not later than five years;	187	182
- later than five years.	703	729
Total	**937**	**957**

Note 10.2 Surrey And Sussex Healthcare NHS Trust as a Lessee

	2018/19 £000	2017/18 £000
Operating lease payables		
Minimum lease receipts	12	-
Total	**12**	**-**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	74	-
- later than one year and not later than five years;	142	-
Total	**216**	**-**

In 2017/18 there were monthly rental charges rather than vehicle lease contracts.

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	100	26
Total finance income	**100**	**26**

Note 12.1 Finance expenses

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	500	791
Finance leases	107	54
Total interest expense	**607**	**845**
Unwinding of discount on provisions	2	5
Total finance costs	**609**	**850**

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

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

There were no gains or losses in 2018/19 or in 2017/18.

Note 14.1 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**9,917**	**9,917**
Additions	815	**815**
Disposals / derecognition	(2,227)	**(2,227)**
Valuation / gross cost at 31 March 2019	**8,505**	**8,505**
Amortisation at 1 April 2018 - brought forward	**8,133**	**8,133**
Provided during the year	647	**647**
Disposals / de-recognition	(2,227)	**(2,227)**
Amortisation at 31 March 2019	**6,553**	**6,553**
Net book value at 31 March 2019	**1,952**	**1,952**
Net book value at 1 April 2018	**1,784**	**1,784**

Note 14.2 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**9,155**	**9,155**
Additions	762	**762**
Valuation / gross cost at 31 March 2018	**9,917**	**9,917**
Amortisation at 1 April 2017 - as previously stated	**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 15.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	12,400	148,961	272	52,071	33	18,077	5,452	237,266
Additions	0	6,117	2,847	5,282	0	2,730	227	17,203
Impairments	0	(783)	0	0	0	0	0	(783)
Revaluations	285	(1,670)	0	0	0	0	0	(1,385)
Reclassifications	75	(75)	0	0	0	0	0	0
Disposals / de-recognition	0	0	0	(20,792)	(33)	(6,225)	(1,883)	(28,933)
Valuation/gross cost at 31 March 2019	12,760	152,550	3,119	36,561	0	14,582	3,796	223,368
Accumulated depreciation at 1 April 2018 - brought forward	0	142	0	37,212	33	14,463	4,163	56,013
Provided during the year	0	4,407	0	2,729	0	1,466	322	8,924
Revaluations	0	(4,348)	0	0	0	0	0	(4,348)
Disposals / de-recognition	0	0	0	(20,784)	(33)	(6,225)	(1,883)	(28,925)
Accumulated depreciation at 31 March 2019	0	201	0	19,157	0	9,704	2,602	31,664
Net book value at 31 March 2019	12,760	152,349	3,119	17,404	0	4,878	1,194	191,704
Net book value at 1 April 2018	12,400	148,819	272	14,859	0	3,614	1,289	181,253

Note 15.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	12,100	138,242	633	48,535	33	16,969	5,152	221,664
Additions	0	7,641	150	3,536	0	1,108	300	12,735
Revaluations	300	3,539	0	0	0	0	0	3,839
Reclassifications	0	511	(511)	0	0	0	0	0
Disposals / de-recognition	0	(972)	0	0	0	0	0	(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 - as previously stated	0	111	0	34,554	33	12,931	3,850	51,479
Provided during the year	0	4,138	0	2,658	0	1,532	313	8,641
Revaluations	0	(4,058)	0	0	0	0	0	(4,058)
Disposals / de-recognition	0	(49)	0	0	0	0	0	(49)
Accumulated depreciation at 31 March 2018	0	142	0	37,212	33	14,463	4,163	56,013
Net book value at 31 March 2018	12,400	148,819	272	14,859	0	3,614	1,289	181,253
Net book value at 1 April 2017	12,100	138,131	633	13,981	0	4,038	1,302	170,185

Note 15.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019							
Owned - purchased	12,760	149,745	3,119	14,899	4,840	1,186	**186,549**
Finance leased	-	1,266	-	1,924	-	-	**3,190**
Owned - donated	-	1,338	-	581	38	8	**1,965**
NBV total at 31 March 2019	**12,760**	**152,349**	**3,119**	**17,404**	**4,878**	**1,194**	**191,704**

Note 15.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£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 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 17 Revaluations
A full revaluation of the Trust site was carried out as at 31 March 2018 by DVS Property Specialists for the Public 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 13 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 lifed assets.

Upward revaluation arising from the revaluation of the buildings has been taken to the revaluation reserve.

Note 18 Investment Property
Not relevant for this Trust

Note 19 Investment property income and expenses
Not relevant for this Trust

Note 20 Other investments / financial assets (non-current)
Not relevant for this Trust

Note 21 Disclosure of interests in other entities

The Trust has had no interests in other entities in either 2018/19 or 2017/18

Note 22 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	898	881
Consumables	3,456	4,182
Total inventories	**4,354**	**5,063**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £36,013k (2017/18: £31,206k). Write-down of inventories recognised as expenses for the year were £73k (2017/18: £27k).

No inventories have been pledged as security for liabilities in either 2018/19 or 2017/18.

Note 23.1 Trade and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	22,326	0
Trade receivables*	0	17,915
Accrued income*	0	5,920
Allowance for impaired contract receivables / assets*	(2,296)	0
Allowance for other impaired receivables	0	(2,119)
Prepayments (non-PFI)	2,001	1,454
PDC dividend receivable	97	0
VAT receivable	1,275	752
Other receivables	339	429
Total current trade and other receivables	**23,742**	**24,351**
Non-current		
Deposits and advances	11	11
Prepayments (non-PFI)	333	99
Finance lease receivables	3,872	3,872
Total non-current trade and other receivables	**4,216**	**3,982**
Of which receivables from NHS and DHSC group bodies:		
Current	16,133	17,694

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 23.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**-**	**2,119**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,119	(2,119)
New allowances arising	536	0
Reversals of allowances	(263)	0
Utilisation of allowances (write offs)	(96)	0
Allowances as at 31 Mar 2019	**2,296**	**0**

Note 23.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**1,748**
Increase in provision	730
Unused amounts reversed	(359)
Allowances as at 31 Mar 2018	**2,119**

Note 24 Other assets

Not relevant to this Trust.

Note 25 Liabilities in disposal groups

Not relevant to this Trust.

Note 26.1 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**5,279**	**5,575**
Net change in year	4,866	(296)
At 31 March	**10,145**	**5,279**
Broken down into:		
Cash at commercial banks and in hand	3	5
Cash with the Government Banking Service	10,142	5,274
Total cash and cash equivalents as in SoFP	**10,145**	**5,279**
Bank overdrafts (GBS and commercial banks)	0	0
Total cash and cash equivalents as in SoCF	**10,145**	**5,279**

Note 26.2 Third party assets held by the trust

The Trust does not hold any third party assets.

Note 27.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	10,208	8,056
Capital payables	4,516	2,333
Accruals	10,510	10,198
Social security costs	0	2,106
Other taxes payable	1,062	1,775
PDC dividend payable	0	29
Accrued interest on loans*	0	27
Other payables	277	269
Total current trade and other payables	**26,573**	**24,793**
Non-current		
Other payables**	3,106	3,212
Total non-current trade and other payables	**3,106**	**3,212**
Of which payables from NHS and DHSC group bodies:		
Current	5,893	3,010

* Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 27.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 28 Other financial liabilities

	31 March 2019 £000	31 March 2018 £000
Non-current		
Other financial liabilities **	-	-
Total	-	-

** Following adoption of IFRS 9 on 1 April 2018, non-current payables are now classified as other financial liabilities. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 29 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,167	1,916
Total other current liabilities	**2,167**	**1,916**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 30 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	1,592	1,562
Obligations under finance leases	547	523
Total current borrowings	**2,139**	**2,085**
Non-current		
Loans from the Department of Health and Social Care	16,243	21,505
Obligations under finance leases	2,836	3,146
Total non-current borrowings	**19,079**	**24,651**

Note 31 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2018	**23,067**	**3,669**	**26,736**
Cash movements:			
Financing cash flows - payments of principal	(5,262)	(395)	**(5,657)**
Financing cash flows - payments of interest	(497)	(107)	**(604)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	27	0	**27**
Additions	0	109	**109**
Application of effective interest rate	500	107	**607**
Carrying value at 31 March 2019	**17,835**	**3,383**	**21,218**

Note 32 Finance leases

Note 32.1 Surrey And Sussex Healthcare NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Surrey And Sussex Healthcare NHS Trust is the lessor:

The deferred receivable relates to the Canada House accommodation block at East Surrey Hospital; the building will revert back to ownership of the Trust at the end of the lease to A2 Housing Group. The lease commenced on 16 May 2008 for 35 years.

	31 March 2019 £000	31 March 2018 £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

* Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 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 2019 £000	31 March 2018 £000
Gross lease liabilities	**3,383**	**3,669**
of which liabilities are due:		
- not later than one year;	547	523
- later than one year and not later than five years;	1,877	1,849
- later than five years.	959	1,297
Net lease liabilities	**3,383**	**3,669**
of which payable:		
- not later than one year;	547	523
- later than one year and not later than five years;	1,877	1,849
- later than five years.	959	1,297

Analysis of Finance leases liabilities	31 March 2019 £000	31 March 2018 £000
Bed Hire Contract (7 year contract from Nov 2017 to Oct 2024)	1,748	2,024
Earlswood Health Centre Lease (leased until 2030)	1,302	1,361
Trust's Public Internet (leased until March 2022)	78	79
E-Rostering System (leased until March 2020)	60	101
Franking machines (various machines leased until 2024)	78	104
Tissue Processors	117	0
	3,383	3,669

Note 33.1 Provisions

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**1,549**	**464**	**81**	**13**	**2,107**
Change in the discount rate	(17)	(7)	0	0	**(24)**
Arising during the year	108	19	25	0	**152**
Utilised during the year	(147)	(31)	0	0	**(178)**
Reversed unused	(9)	0	0	(13)	**(22)**
Unwinding of discount	2	0	0	0	**2**
At 31 March 2019	**1,486**	**445**	**106**	**0**	**2,037**
Expected timing of cash flows:					
- not later than one year;	147	31	106	0	**284**
- later than one year and not later than five years;	587	125	0	0	**712**
- later than five years.	752	289	0	0	**1,041**
Total	**1,486**	**445**	**106**	**0**	**2,037**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within Pensions / Early departure costs.

Early Departure costs includes early retirements 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 2019, £132,708k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Surrey And Sussex Healthcare NHS Trust (31 March 2018: £119,505k).

Note 34 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
Other	(31)	(35)
Gross value of contingent liabilities	**(31)**	**(35)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(31)**	**(35)**
Net value of contingent assets	**0**	**0**

Note 35 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	4,297	216
Intangible assets	53	18
Total	**4,350**	**234**

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 to the Trust

Note 39 Off-SoFP PFI, LIFT or other service concession arrangements

Not relevant to the 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 2019 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

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	23,539	-	-	**23,539**
Cash and cash equivalents at bank and in hand	10,145	-	-	**10,145**
Total at 31 March 2019	**33,684**	**-**	**-**	**33,684**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
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**

Note 40.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	17,835	-	**17,835**
Obligations under finance leases	3,383	-	**3,383**
Trade and other payables excluding non financial liabilities	22,967	-	**22,967**
Total at 31 March 2019	**44,185**	**-**	**44,185**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	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**

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 2019	31 March 2018
	£000	£000
In one year or less	25,103	22,545
In more than one year but not more than two years	2,046	2,075
In more than two years but not more than five years	6,078	6,022
In more than five years	10,958	16,557
Total	**44,185**	**47,199**

Note 41 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	35	43	19	51
Fruitless payments	5	-	9	1
Bad debts and claims abandoned	95	107	41	53
Stores losses and damage to property	16	161	16	69
Total losses	**151**	**311**	**85**	**174**
Special payments				
Compensation under court order or legally binding arbitration award	9	17	14	86
Ex-gratia payments	21	8	14	13
Total special payments	**30**	**25**	**28**	**99**
Total losses and special payments	**181**	**336**	**113**	**273**
Compensation payments received		-		-

Note 42 Gifts

There were no gifts for the Trust during the reporting period.

Note 43.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £27k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £927k.

Note 43.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The IFRS15 standard has had no material impact for the Trust.

Note 44 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 and Social Care 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
Coastal West Sussex CCG
Croydon CCG
NHS England
Sussex Community NHS Foundation 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

The Trust has also received revenue and capital payments from a number of charitable funds including the SASH Charity, certain of the Trustees for which are also members of the Trust board. The Trust received £155k from the League of Friends in 2018-19.

Note 45 Transfers by absorption

Not relevant for this Trust

Note 46 Prior period adjustments

Not relevant for this Trust

Note 47 Events after the reporting date

Not relevant for this Trust

Note 48 Final period of operation as a Trust providing NHS healthcare

Not relevant for this Trust

Note 49 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	86,072	116,932	81,723	105,638
Total non-NHS trade invoices paid within target	82,361	111,457	62,768	82,440
Percentage of non-NHS trade invoices paid within target	95.7%	95.3%	76.8%	78.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,247	9,302	2,391	15,664
Total NHS trade invoices paid within target	1,800	8,683	2,091	14,622
Percentage of NHS trade invoices paid within target	80.1%	93.3%	87.5%	93.4%

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

Note 50 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	(5,847)	(4,014)
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	(5,847)	(4,014)
External financing limit (EFL)	1,336	(650)
Under / (over) spend against EFL	7,183	3,364

Note 51 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	18,018	13,497
Less: Disposals	(8)	(923)
Less: Donated and granted capital additions	(229)	(173)
Charge against Capital Resource Limit	17,781	12,401
Capital Resource Limit	18,758	12,401
Under / (over) spend against CRL	977	0

Note 52 Breakeven duty financial performance

	2018/19 £000	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	11,203	13,641
Breakeven duty financial performance surplus / (deficit)	11,203	13,641

Note 53 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		7,755	875	(6,056)	254	298	(2,374)	(6,531)	3,672	13,641	11,203
Breakeven duty cumulative position	(47,098)	(39,343)	(38,468)	(44,524)	(44,270)	(43,972)	(46,346)	(52,877)	(49,205)	(35,564)	(24,361)
Operating income		194,896	196,030	209,582	226,016	231,702	244,007	264,879	286,335	315,421	336,169
Cumulative breakeven position as a percentage of operating income		**(20.2%)**	**(19.6%)**	**(21.2%)**	**(19.6%)**	**(19.0%)**	**(19.0%)**	**(20.0%)**	**(17.2%)**	**(11.3%)**	**(7.2%)**

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.