NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS

1 April 2019 to 31 March 2020

Together we care

Ashford and St. Peter’s Hospitals NHS Foundation Trust

Annual Report and Accounts 2019-20

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

Contents

1. INTRODUCTION

Welcome statement by the Chairman, Andy Field

Welcome to our Annual Report which covers the financial period from 1 April 2019 to 31 March 2020. I remain extremely proud to be part of this caring, committed and hard-working organisation. The last year was another incredibly busy year during which we worked innovatively and collaboratively to find new ways to provide outstanding care, also to meet the ever increasing demand upon our services.

During the year, we have continued to work with system partners in the Surrey Heartlands Health and Care Partnership and we have also started to forge important new relationships with local businesses and communities in our journey to become an anchor institution.

Towards the end of this year we, alongside the entire NHS, have been required to respond to the most extraordinary challenges brought about by the COVID-19 pandemic. I feel immensely proud of the way in which team ASPH has risen to meet this challenge, from rapidly and completely changing the ways we work and deliver care, to creating vital additional capacity, and to displaying outstanding team work, through care and compassion for one another as well as for our patients. I feel proud to stand with all my colleagues, and wish to extend my deepest and heartfelt thanks to the whole team.

Some highlights from the year include:

The inaugural and hugely successful community day, which saw St. Peter's Hospital open their doors to welcome over 300 visitors of all ages and provide interactive stands and activities throughout the hospital for teams to showcase their departments and specialties. The Trust was also supported by various partners including Radio Wey, Surrey Police, South East Coast Ambulance Service, St John's Ambulance and The Army Reserve and Cadets. It was lovely to see families come together to find out more about everything the Trust has to offer. This marked the start of our journey to become an Anchor institution, work which is now being taken to a new level through our partnership with Well North Enterprises. During the day we also signed the military covenant which enshrines our commitment to the serving members of the armed forces as well as veterans and their families.

Collaboration – we explored new and innovative ways of providing services: one example was the relocation of traditionally hospital based physiotherapy services to the River Bourne Gym in Chertsey; to date this has been a great success which importantly reduces the need and impact of patient travel to the hospital site as well as embedding services within the communities we serve.

The commencement of extensive building works to transform the site, starting with a new Nursery at Ashford, a new 33 bed Acute Medical Unit and work commencing on the new multi-storey car park and front hospital entrance which will include the creation of a staff well-being centre due to be completed in 2020.

Signing the contract for an electronic patient record platform in collaboration with Royal Surrey NHS Foundation Trust and being one of the first trusts to be awarded Digital Aspirant status by NHSX.

2019/20 was another challenging year, during which we have continued to focus on providing the highest quality care whilst coping with increased demand and delivering within a tough financial envelope. We faced sustained operational challenges with increasing emergency demand in particular, putting ever greater pressure on our systems and those of our wider system partners. Despite this, our continued collaborative efforts to deliver high quality, efficient and effective care really made a difference and have also enabled us to maintain a good financial position.

The Trust has a strong and well established Board and I would particularly like to thank Sue Tranka, Chief Nurse, who left in December 2019 to take up a secondment with NHS England as Deputy Chief Nursing Officer for Innovation and Safety. In this important new role, Sue is leading the national work to support implementation of the NHS Patient Safety Strategy. In her stead, we welcomed Andrea Lewis as Interim Chief Nurse in December 2019. Andrea was previously the Deputy Chief Nurse and has held a number of roles within the Trust following a long and successful military career. The Board are delighted she will bring this experience to the role of Chief Nurse.

I would also like to thank Hilary McCallion who stepped down as Non-Executive Director in July 2019 to pursue other roles. We are grateful for the knowledge and expertise Hilary brought to the Trust, especially in her role as Chair of the Quality Committee. In her stead we welcome Jane Dale as Non-Executive Director. Jane was appointed in January 2020 and has an extensive and diverse background working within the NHS having initially qualified as a registered nurse and midwife.

Andy Field, **Chairman**

'We have had a tough year with unprecedented pressure at the end due to COVID-19 but my colleagues at Ashford and St. Peter's have exemplified caring, not just for our patients but also for each other. **#ItTakesaTeam**'

We continue to work collaboratively with our Council of Governors and I would like to take the opportunity to thank the following Governors who either came to the end of their maximum three terms or stood down in 2019: Steve McCarthy, Public Governor for Elmbridge, Godfrey Freemantle, Public Governor for Hounslow, Kingston-upon-Thames and Richmond-upon-Thames, Bhagat Singh Rupal, Public Governor for Hounslow, Kingston-upon-Thames and Richmond-upon-Thames, Simon Bhadye, Public Governor for Spelthorne, Brian Catt, Public Governor for Spelthorne, Denise Saliagopoulos, Public Governor for Spelthorne, Keith Bradley, Public Governor for Woking and Guildford, Maurice Cohen, Public Governor for Woking and Guildford, Judith Moore, Public Governor for Woking and Guildford and Sue Harris, Staff Governor for Nursing and Midwifery staff. Their hard work since the Trust became a Foundation Trust has been invaluable and is much appreciated.

I would like to welcome our new Governors; Edwin Addis, Public Governor for Hounslow, Kingston-upon-Thames and Richmond-upon-Thames, Neal Adolphus, Public Governor for Spelthorne, Miranda Alcock, Public Governor for Woking and Guildford, Derek Barnes, Public Governor for Spelthorne, Tracey Bradshaw, Staff Governor for Nursing and Midwifery, Shirley Holmes, Public Governor for Woking and Guildford, Colin Hood, Public Governor for Spelthorne, Hina Malik, Public Governor for Hounslow, Kingston-upon-Thames and Richmond-upon-Thames and Helen Pernelet, Public Governor for Elmbridge and to thank them for taking on such an important role.

I would also like to take this opportunity to thank everyone who plays such an important role in the running of the hospitals and contributes to the provision of excellent patient care. Firstly, to all my colleagues at Ashford and St. Peter's, who give so much every single day including our dedicated and much valued team of volunteers, whom we are lucky to have and value greatly. Finally, I'd like to extend a heartfelt thanks for their support to all of our local partners: including commissioners, the ambulance service, local authorities, social care, primary care, community providers and mental health service colleagues; and to our members, the local voluntary sector, fundraisers and members of the community who support us so well.

Andy Field
Chairman

About us

Established in 1998 from the merger of Ashford and St. Peter's Hospitals, the Trust has been on a long journey of development and improvement to its current position as the largest provider of acute hospital services to Surrey residents. It became a Foundation Trust in December 2010.

Ashford and St. Peter's Hospitals NHS Foundation Trust serves a population of more than 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow, Surrey Heath and beyond. The Trust employs around 4200 individual members of staff. Our turnover was £343.4 million in 2019/20.

The Trust provides a whole range of services across its hospital sites. The majority of planned care, like day case and orthopaedic surgery and rehabilitation services, is provided at Ashford Hospital, with more complex medical and surgical care and emergency services at St. Peter's Hospital.

Our catchment area

We've been busy

During the year we have:

TREATED
33,500
EMERGENCY ADMISSIONS

ADMITTED
44,500
PEOPLE FOR PLANNED INPATIENT AND DAY CASE TREATMENT

SEEN
111,000
PEOPLE IN OUR A&E DEPARTMENT

TREATED
446,000
PATIENTS IN OUR OUTPATIENT CLINICS

HELPED DELIVER
3,570
BABIES

HAD A TURNOVER OF
£343.4m
WITH A FINANCIAL SURPLUS OF £1.2M

TREATED
26,000
THROUGH VIRTUAL CLINICS

Our services

We provide the following hospital and community based health services to our catchment population:

- Admitted patient care for planned surgery and emergency medicine and surgery
- Accident and emergency services
- Critical care
- Outpatient services, both in the hospitals and across a number of community settings
- Community midwifery services.

Services are split across our three main hospital sites as follows.

Ashford Hospital

- Day-case surgery
- Elective Surgery
- Ophthalmology
- Outpatients (including paediatrics) and diagnostics; X ray, ultrasound, and MRI scans
- Inpatient Rehabilitation
- Outpatient Midwifery hub

St. Peter's Hospital

- Accident and emergency services
- Intensive care
- Emergency surgical and medical care
- Elective and day-case surgery
- Orthopaedics (Rowley Bristow unit)
- Maternity care
- Paediatric services (children's services)
- Neonatal intensive care unit which provides care for acutely ill babies
- Outpatients and diagnostics; X ray, ultrasound, CT scans, endoscopy (using cameras to look inside the body) and MRI scans
- Pathology services (provided through the Surrey and Berkshire Pathology Service)

Woking Community Hospital

- Inpatient Neuro-rehabilitation services
- Outpatient Services
- Physiotherapy

We run a wide range of specialist clinics in the community. These include Cobham Community Hospital, West Byfleet Health Centre, the Heart of Hounslow Centre for Health, Teddington Memorial Hospital and others – providing more accessible care, closer to where our patients live. We also have Early Supported Discharge Teams (for stroke) based at Ashford and Milford hospitals (providing services across much of West Surrey). Dermatology services are provided from Royal Surrey County Hospital, Haslemere Hospital and Cranleigh Health Centre.

Our vision and strategy

Our new Trust Strategy: 'Together We Care' was launched in May 2018 and was developed within the national and local context of there being a clear need for collaboration and partnership working in order to ensure strong foundations for creating and benefiting from strategic opportunities. It is consistent with the local strategies and the Surrey Health and Wellbeing Strategy and, despite being published before publication of the NHS Long Term Plan in January 2019, we were pleased to see a significant degree of alignment between the national priorities set out in the Plan and our own strategy and vision.

Our refreshed vision

'to provide an outstanding experience and best outcomes for patients and the team' and is supported by our values'

Our mission

'to ensure the provision of high quality, sustainable healthcare services to the communities we serve'

By achieving our aims, we want every patient to be able to say:

'I was treated with compassion'

'I was involved in a plan for my care which was understood and followed'

'I was treated in a safe way, without delay'

'And every member of our team to feel able to give their best and feel valued for doing so'

Our Strategic Objectives

Quality of care – creating a learning organisation and culture of continuous improvement to reduce repeated harms and improve patient experience

People – being a great place to work and to be a patient, where we listen, empower and value everyone

Modern healthcare – delivering the most effective and efficient treatment and care through standardisation in the delivery and outcome of clinical services

Digital – using digital technology and innovations to improve clinical pathways, safety and efficiency and empower patients

Collaborate – working with our partners in health and care to ensure the provision of a high quality sustainable NHS to the communities we serve

We continue to play a key role within the Surrey Heartlands Integrated Care System and the developing North West Surrey Integrated Care Partnership, which is an alliance of health and care organisations across North West Surrey and partners including borough councils and the voluntary sector to ensure delivery of care at local level (see more overleaf).

Local context:

Surrey Heartlands Integrated Care System (ICS)

Surrey Heartlands is one of 18 Integrated Care Systems (ICSs) working to improve health and care for the local population. Surrey Heartlands covers the central and western parts of Surrey; those areas currently looked after by Surrey Downs, North West Surrey, Guildford and Waverley and East Surrey. It is also the second ICS in England behind Greater Manchester to have achieved devolution which means it has more local control through devolved budgets and access to further transformational funding.

The Surrey Heartlands Integrated Care System aims to improve services and health outcomes for local people and to add value through working together. System partners take collective responsibility for improving health outcomes, managing resources and delivering NHS standards. Working together, Surrey Heartlands has refreshed its priorities and plan, in line with the ambitions of the NHS Long Term Plan, with a strong focus on the first 1000 days of a person's life, and also aiming to address the wider determinants of health.

As part of its devolution agreement, Surrey Heartlands has also taken on responsibility for self assurance, putting in place governance and assurance mechanisms in relation to quality, performance and financial delivery.

North West Surrey Integrated Care Partnership (ICP)

The Trust continues to be a key partner within the overall ICS represented on the System Board by the Chief Executive and Medical Director and leading and participating in a number of the key work streams. The Chair and representatives of the Non Executive Directors are also actively engaged in the relevant fora for lay members and Non Executive Directors.

In addition, within Surrey Heartlands are four local alliances known as Integrated Care Partnerships which cover the previous CCG boundaries. These are broad based partnerships of local health and care organisations and importantly include other partners such as District and Borough councils, and local voluntary and community organisations. ICPs are particularly focused on improving out of hospital care and bringing organisations and staff together to deliver better joined up care for local people. Within North West Surrey ICP in the last twelve months further significant steps forward have been made and an Independent Chair as also been appointed to the Board. Working with front line staff and local people the ICP has developed a new model of care and has begun to mobilise the first developments in the new model which will focus on supporting care homes, maintaining independence closer to home, proactive community care and Primary Care Networks The ICP now fulfils a combined assurance function in the system, overseeing quality, NHS standards and financial performance together.

The Trust is a key partner within the North West Surrey Health and Care Partnership. The Chief Executive and Director of Strategy and Sustainability are members of the Partnership Board.

More information on Surrey Heartlands is available at: **www.surreyheartlands.uk.**

'As health and local government services have come together to form an Integrated Care Partnership across North West Surrey, ASPH has been a fundamental partner in this work to make people's experience of local services as seamless and high quality as possible. I have always found the Trust to be one of the most forward-thinking I have worked with, recognising that the health of local people is determined by more than the treatment that takes place within the four walls of the hospital; and displaying a drive and a willingness to use the Trust's expertise and resources for the benefit of the wider community and partner organisations in other settings.'

Jack Wagstaff, North West Surrey ICP Director

National policy:

The NHS Five Year Forward View advocates a radical transformation to improve efficiency in the NHS – through transforming care delivery, breaking down organisational and cultural barriers – with more care provided closer to home and within the community, with hospitals focusing on the acute care and intervention that only they can provide.

The NHS Long Term Plan, published in January 2019, builds on the Five Year Forward View and sets out ambitions for ensuring the NHS is Fit for the Future, covering a ten year period.

It encompasses the following key principles:

- New service model
- Action on prevention and health inequalities
- Improvements in care quality and outcomes
- Digitally enabled care
- Value for money.

2. PERFORMANCE REPORT

£1.2m
SURPLUS

£343.4m
TURNOVER

£6.6m
SAVINGS

Performance Report - Overview

Statement by the Chief Executive

Overall, the Trust has performed well against its corporate objectives (see our Performance Analysis section for a more detailed analysis). Financially, we ended the year with a surplus of nearly £1.2 million and within this we delivered £6.6 million of savings from a turnover of £343.4 million which will reinforce our position amongst the most efficient acute Trusts in the country.

Our stable financial position means we can continue to invest in the much needed capital schemes, many of which have already started such as digital developments and our new multi-storey car park. It also offers the opportunity for further developments to improve facilities for the team and for patients.

We continue to strive towards the delivery of our Together We Care Strategy and towards outstanding experience and the best outcomes for patients and the team. Delivery is focused on the five strategic objectives and one of the means by which we can understand the fulfillment of the strategy is through our performance.

During 2019/20 we placed significant focus on our emergency care pathway with much hard work put in by teams across the hospitals and the local system through the Making Every Day Count programme. Like many Trusts we have struggled to meet the four hour waiting target achieving a performance of 76.4%[1] for the year against the target of 95%. However the work we undertook to improve the emergency care pathways meant we were able to create more resilience and maintain stronger performance over the winter months, the result being a significantly improved position both regionally and nationally. Overall, A&E attendances rose during the year by about 5.2% reaching over 100,000 for the third year in a row despite a steep decline in attendances during March 2020 due to COVID-19.

Following on from last year, the Trust has seen a further 9.2% increase in urgent cancer referrals this year (35% increase over the last three years); we did not achieve all of the cancer targets for 2019/20 overall and improving cancer waiting times is a continued area of focus for the coming year.

The Trust also started the year with an improving RTT[2] position and we remained compliant for nine months between April and December, when winter pressures and the requirement to defer non-urgent elective surgery caused the Trust to become marginally non-compliant during January and February. Due to the further impact of COVID-19 and associated infection control restrictions (including patient choice) during March, the Trust's RTT position fell to 88.2%.

[1]St Peter's activity only
[2]Referral to Treatment

At the start of the year, staffing remained one of the biggest challenges and a huge amount of work has been done to control agency costs and increase the numbers of staff in substantive posts through expansion of recruitment and retention campaigns. We have continued to place a strong focus on wellbeing whilst recognising the importance of retaining existing staff through reward and recognition initiatives. We have increased the number of substantive staff in post by almost 400 and have significantly reduced vacancy rates across all staff groups but particularly in nursing and midwifery.

We continue to work closely with clinical commissioners, in particular Surrey Heartlands Clinical Commissioning Group (CCG) who commissions the majority of our services (representing over 80% of our clinical income). We also have good relationships with other commissioners, including Hounslow CCG (representing c.4% of our clinical income) and CCGs in Berkshire (who represent c.2.5%). We continue to work well with NHS England who commissions the specialist services we provide including cardiovascular and neonatal services with a contract value of around £31 million (c.12% of our clinical income).

During the course of the year we have continued to perform well against the strategic objectives, which are encompassed within our Together We Care Strategy. In particular, under the Collaborate objective, we have developed new and strengthened existing links with partner organisations. This work has formed part of our journey to become an Anchor institution, which actively interacts with the local community to improve the health and well being, as well as the economic environment of the community. As we end the year facing new and unprecedented challenges due to COVID-19, the support we have received from the community has been incredible and has served to deepen our understanding of how we can strengthen our role as an Anchor Institution. It has never been more important to deliver our mission 'to ensure the provision of high quality, sustainable healthcare services to the communities we serve'.

Suzanne Rankin
Chief Executive

Suzanne Rankin
Chief Executive

29 June 2020

NB: Suzanne Rankin was seconded to NHS Test and Trace as their National Director of Containment on 1 June 2020 for a period of three months. The Board appointed Dr David Fluck as the Acting Chief Executive and Accounting Officer during her period of secondment. The acting Chief Executive and Accounting Officer has therefore signed this Annual Report and Accounts

Key issues and risks

Taking into account both external and internal factors and uncertainties, as part of our risk management process, we have identified the following key risks to our strategic objectives:

Strategic Objective: Quality of care

1.1	Failure to achieve avoidable mortality and safer more efficient patient care through an inability to deliver: the priority quality improvement and transformation programmes (learning from deaths, medication and infection control strategic improvement programmes) due to insufficient capacity and capability.
1.2	Failure to improve and achieve outstanding patient experience through an inability to harness and optimise learning from patient and family feedback due to insufficient capacity and capability.

Strategic Objective: Modern healthcare

2.1	Non-delivery of the annual operating plan may lead to loss in productivity / efficiency and financial standing.
2.2	A failure to maintain the Trust's physical environment and clinical infrastructure, may lead to clinical pathway difficulties, deteriorating patient and staff experience, patient safety, and health and safety risks.
2.3	A failure to deliver constitutional and operational targets leading to increased patient delay, poor patient experience, increased patient safety risks, increased outsourcing or activity and corresponding loss in productivity / efficiency.

Strategic Objective: Digital

3.1	The Trust's service delivery may be compromised if the current strategy to exploit the electronic patient record fails.
3.2	Failure of key IT systems leads to patient safety, experience or quality risks, data security breaches or process delays.

Strategic Objective: People

4.1	Inability to align workforce supply to meet current and future acuity and demand, resulting in a misalignment with both the service and financial plan.
4.2	Inability to recruit and retain, leading to a poor staff and patient experience.
4.3	Individuals and teams do not feel listened to, empowered and valued resulting in a negative impact on staff and patient experience.

Strategic Objective: Collaborate

5.1	Insufficient capability and capacity to deliver the strategy programme (i.e. the strategic objectives) in accordance with the operating plan so that effect is diminished and/or service sustainability is significantly challenged.
5.2	External factors, such as decisions taken nationally, ICS, ICP, impact our delivery or attempt to counter our objectives or undermine our service sustainability.
5.3	Desired effect of the strategy does not realise the intended benefits to quality and sustainability of patient care.
5.4	Effective external relationships established do not sustain.

For more detail on how we manage and respond to risk see our Annual Governance Statement on page 107.

Going concern disclosure

After making enquiries, the directors have a reasonable expectation that Ashford and St. Peter's Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

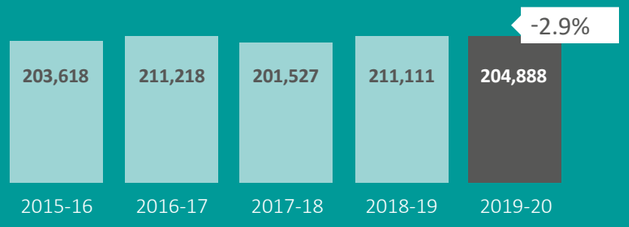
Detailed activity review

Outpatients

New outpatient attendances
Outpatient activity decreased by 4.2% as a result of a transfer of activity to non- face to face attendances, significant changes to the physiotherapy service as services were deployed into local GP practices and in March a reduction in activity as a result of COVID-19.

121,957 -4.2%
NEW OUTPATIENT APPOINTMENTS

Outpatient follow-up attendances
The patent activity declined at the end of the year due to COVID-19 pandemic.



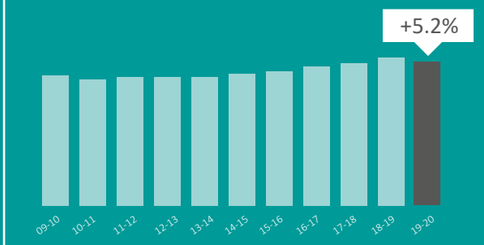
Outpatient procedures
We continued to see an increase in the number of outpatient procedures, in particular there was a large increase in ophthalmology treatments.

+12.1%
OUTPATIENT PROCEDURES INCREASE

26,263
NON FACE-TO-FACE CONSULTATIONS

+16.6%
INCREASE IN VIRTUAL CLINICS APPOINTMENTS

A&E attendances
The Trust saw more patients during the year until March when there was a steep decline in attendances due to the COVID-19 outbreak.



33,500
EMERGENCY ADMISSIONS

+11.1%
MORE THAN LAST YEAR

Virtual clinic appointments
In line with NHS long-term plans, virtual patient services increased significantly. In haematology one third of patients are cared for virtually. Virtual services are more efficient and better for patients as they prevent unnecessary patient visits to hospital.

111,772
PEOPLE SEEN IN A&E

+900
PATIENTS PER MONTH ATTENDED A&E THIS WINTER, MOSTLY CHILDREN

Emergency admissions
Emergency admission increased compared to the previous year, this was partly due to a change in the national requirements regarding the way these were recorded.

38,680
DAY CASE PROCEDURES

+19%

Day case procedures
The large increase in additional day cases meant reduced waiting times meeting national 18 week target. Additional local chemotherapy provision and increased endoscopy activity all contributed to the increase

6,565
ELECTIVE ADMISSIONS

-1.5%

Elective (planned) admissions
Activity was largely the same as previous year however the COVID-19 pandemic impacted upon elective activity which reduced during March 2020

3,570 -5%
BIRTHS

Births
This small change reflects the birth rate reduction across the north west Surrey catchment area.

Key performance metrics

The following table describes how we have performed against key national targets and minimum standards, giving overall performance against target for the year, performance by Quarter as well as how this year compares to previous years.

National Targets and Minimum Standards	Target	Target (2019/20)	2019/20	2019/20				2018/19	2017/18	2016/17
				Q4	Q3	Q2	Q1			
Infection Control	Number of clostridium difficile cases	28	27	4	9	7	7	14	15	20
	Number of MRSA blood stream infection cases	0	2	2	0	0	0	0	1	0
Access to Cancer Services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	97.1%	98.1%	96.9%	96.3%	97.3%	97.9%	98.5%	97.8%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98%	99.3%	100%	100%	97.1%	100%	100%	100%	100%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	78.0%	89.7%	67.7%	84.4%	71.0%	94.8%	96.9%	94.7%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment	85%	84.1%	82.2%	88.0%	83.8%	81.9%	85.8%	87.2%	83.6%
	% of cancer patients waiting a maximum of 2 months from the consultant screening service referral to treatment	90%	90.0%	82.1%	100%	94.7%	86.2%	92.1%	94.0%	92.7%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	93.7%	94.4%	93.9%	93.4%	93.1%	92.4%	93.2%	94.8%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	97.4%	98.6%	96.1%	97.1%	98.1%	97.2%	96.5%	96.8%
Access to Treatment	18 weeks Referral to Treatment - patients on an incomplete pathway	92%	92.0%	90.6%	92..9%	92.4%	92.3%	91.2%	92.0%	93.2%
Access to A&E (SPH)	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge (St. Peter's site only)	95%	76.4%	74.8%	76.4%	79.2%	74.9%	79.0%	85.1%	85.3%
Access to A&E (NHSI)	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge NHSI: including Woking and Ashford	95%	86.1%	84.6%	85.9%	88.0%	85.8%	88.4%	91.0%	90.6%
Access to patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	n/a	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Our performance explained

Infection control – hospital acquired infections

There were 27 cases of post 72 hour clostridium difficile infections recorded during 2019/20, against a target of no more than 28. Of these, seven were considered to have had a lapse in care through antimicrobial prescribing and/or delay in patient isolation, four cases were in review at the end of the year. The investigation outcome and required learning has been implemented by the clinical teams.

There were 2 cases of MRSA bacteraemia during 2019/20. The first case occurred whilst a patient was in ITU, cause due to pneumonia, with no lapses in care identified. The second case occurred whilst a patient was in BACU[3], cause due to a line source of infection, with no lapses in care identified.

Access to Cancer Treatment

The Trust received 18,500 urgent cancer referrals during the year, an overall 9.2% increase compared to the previous year, although a total 35% increase over the previous 3 year period. We continue to work with our commissioners at North West CCG to address these increases and support delivery of compliant performance.

The Trust achieved annual compliance for cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen, although marginally missed annual compliance for treatment within 62 days. However, the Trust's performance compares extremely well against the England national average performance for treatment within 62 days.

During a number of months we experienced difficulties in meeting the 62 day standard for urgent GP referrals due to the increase seen in demand, delays caused by complex difficult cross-over pathways between the Trust and tertiary partners, patient choice & fitness, and capacity due to emergency care pressures. Further improvement in these areas are being planned through combined system and provider improvements.

Improving cancer waiting times is a continued area of focus. Work is being undertaken with primary care in patient engagement, and ensuring the Trust, partner and tertiary providers have sufficient ongoing capacity to meet the ongoing increases being seen in demand to maintain and improve compliance.

[3]BACU- Birch Acute Cardiac Unit

In terms of monitoring performance, a weekly Cancer oversight meeting is held (chaired by the Deputy Chief Operating Officer) which specifically monitors cancer performance and progression of our cancer improvement plans, with monthly meetings also held with the Trust's lead commissioner.

Referral to Treatment (18 week target)

The Trust started the year with an improving although non-compliant RTT position of 91.5% (Mar 19) due to the significant impacts detailed in last year's Annual Report.

The Trust continued to improve the RTT position, remaining compliant through April to December (9 months), until winter pressures and the requirement to defer non-urgent elective surgery caused the Trust to become marginally non-compliant during January and February. However, with the impact of COVID-19 and associated infection control restrictions (including patient choice) during March, the Trust's RTT position fell to 88.2%.

The Trust's level of performance during the year placed it consistently within the top 10 performing Trust's for RTT performance across England (with 10,000+ patients on their waiting list). The Trust's performance also contrasted favourably against the average England performance which was non-compliant throughout the whole year.

In terms of monitoring performance, specialty level 'patient list' meetings are held weekly. The aim of these meetings, chaired by the relevant service managers, is to identify key delays along the pathway in particular with the assessment and admission process. Our aim is to keep the number of cancelled operations and other treatments to an absolute minimum at all times, and to ensure surgery and treatments are rebooked as soon as possible if a cancellation is necessary.

This forum also oversees the correct application of rules, and plans and manages patient pathways within the specialty ensuring patients are dated by clinical priority. Issues requiring escalation are resolved where possible within the divisional management team as part of business as usual processes. A summary of performance along with the identification of risks is presented to the Trust Performance Committee (chaired by the Deputy Chief Operating Officer or Associate Director of Performance) on a weekly basis.

A&E four hour waiting target

Like many providers across England, the Trust struggled with the A&E four hour waiting target throughout the year recording a total of 86.1% (NHSI) for the full year and 85.8%, 88.0%, 85.9% and 84.6% respectively for the four quarters of the year.

However, the Trust provided significant effort into improving emergency care pathways during the year and as a result, was able to create more resilience and maintain stronger performance over the winter months, with the Trust improving regionally and nationally from the 2nd quartile of performance to the 4th quartile (where 4th quartile is the highest).

Performance dipped during the year as patient flow across the system was impacted due to; (a) higher than average surges of admissions, (b) reduced staff availability due to vacancies, (c) shortage of community support, and (d) slow flow to the wards creating delays in A&E. The Trust also cared for a greater number of higher acuity patients where patients required a longer length of stay in hospital before their safe discharge.

Challenges regarding inpatient flow have continued to dominate and exacerbate our emergency department pressures with exit block (when patients are unable to be moved from A&E) from the Emergency Department to inpatient wards an ongoing challenge.

An overarching recovery programme was instituted during the year with the support of a specialist partner. Our programme, entitled 'Making Every Day Count' oversaw improvement work to ED process, inpatient flow, ambulatory care and discharge from hospital.

Although A&E performance for the year dropped marginally compared to the previous year, the Trust's position when compared to providers both regionally and nationally improved substantially, confirming the resilience the recovery programme achieved.

A&E performance is monitored on multiple occasions during each day at regular Capacity Action Team (CAT) meetings held with key hospital operational staff. At the programme level, meetings were held weekly to manage the improvement work-streams, with a direct line of reporting through to the Trust Board.

Trust wide Assurance and Governance

The Trust has a series of fixed weekly and monthly milestone points where performance is reviewed, managed and assured. Separate forums exist to scrutinise performance and improvement actions in each of the three key domains (A&E, 18 week referral to treatment, and Cancer) as detailed above.

All elements of business performance, quality and workforce issues are discussed at monthly Divisional Performance reviews attended by the Divisional leadership team (including clinical leads) and the Trust Executive team. All these forums are supported by a series of reporting tools which provide the basis for effective performance management and accountability.

Trust wide performance is then reviewed within the bi-monthly Quality of Care Committee and Modern Healthcare Committee before being presented to the Trust Board for further scrutiny.

The Trust also provided weekly and monthly performance updates to North West Surrey CCG and meetings where appropriate to review all aspects of Trust performance, including recovery and future planning capacity to deliver compliance.

The fortnightly System wide Local A&E Delivery Board meeting (chaired by North West Surrey CCG) meets monthly with representation from the Trust, the CCG and key health system partners to review and assure current and future performance across the local system while determining where gaps in service and planning exist, and implementing plans to address any shortfalls.

Financial performance

2019/20 was another year where we faced a really tough financial and operating environment, during which we focussed on providing the highest quality care, on maintaining our waiting list performance and on reducing our reliance on temporary staffing.

We faced sustained operational, workforce and financial challenges with increasing emergency demand, putting ever greater pressure on our systems. Similar pressures also affected our wider system partners leading to challenges generating sufficient patient flow through our hospitals. The year ended with the start of the COVID-19 pandemic which entailed reworking all of our services, expanding critical care and our respiratory provision, while curtailing other services. Despite this our continued efforts to deliver high quality, efficient and effective care really made a difference and as a result we have continued to maintain our strong financial position.

There will be significant changes to the way we provide services and much to learn from the COVID-19 pandemic which will be reflected fully in our Annual Report for 2020/21.

Crucially, we embarked on a number of significant new investments intended to fundamentally redesign our offering to both the public and staff. We relocated all the services formerly on the West site to new locations, demolished the former ramp buildings and commenced the new multi decked car park build. We built a new ward and an emergency surgery assessment facility at St. Peter's and re-provided the nursery, an infusion suite and new Human Resources offices at Ashford. We also began the next stage of our digital journey with the signing of our new Electronic Patient Record contract.

An analysis of our results is set in the table that follows – this is in the format reported to NHS Improvement for the Finance and Use of Resources theme which forms part of the NHS Oversight Framework- as such this differs slightly from the Annual Accounts analysis.

	2019/20			2018/19		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Income						
Clinical Income	299.2	312.2	13.0	277.9	282.6	4.7
Non-Clinical Income	27.1	30.9	3.8	45.5	52.7	7.2
Total Income	**326.3**	**343.1**	**16.8**	**323.4**	**335.3**	**11.9**
Expenses						
Pay Costs	-198.8	-215.0	-16.2	-188.1	-191.3	-3.2
Non-Pay Costs	-104.8	-111.8	-7.0	-94.6	-103.5	-8.9
Total Expenses	**-303.6**	**-326.8**	**-23.2**	**-282.7**	**-294.8**	**-12.1**
EBITDA	22.7	16.3	-6.4	40.7	40.5	-0.2
Depreciation & Amortisation	-8.3	-8.8	-0.5	-7.6	-7.2	0.4
Impairments, net of reversals	-2.1	-0.5	1.6	-0.6	1.4	2.0
Charitable contributions	0.3	0.3	-	0.6	0.3	-0.3
Interest (net)	-0.1	-	0.1	-0.4	-0.1	0.3
Dividend on PDC	-6.4	-6.1	0.3	-6.1	-6.0	0.1
Net gains on disposal of assets	-	-	-	10.4	18.0	7.6
Movement in fair value of investments	-	-	-	-	-0.1	-0.1
Net surplus/(deficit)	**6.1**	**1.2**	**-4.9**	**37.0**	**46.8**	**9.8**

Key movements year on year are set out below:

- Clinical income increased by £29.6m (10.5%) year on year. This was a result of increased demand leading to higher activity income, combined with increases in tariff income to cover national funding changes, including pay awards.
- Non-clinical income decreased by £21.8m (41.4%) year on year. The main reason for this was the decreased Provider Sustainability Fund allocation that the Trust could earn for the delivery of performance targets. The Trust received £5.1m as a result of meeting these targets compared to £32.8m received in 2018/19, with the prior year inflated by the receipt of bonus and incentive allocations.
- Pay costs were £23.7m (12.4%) higher than 2018/19, of which £8.0m relates to an increase in the employers contribution rate to the NHS Pension Scheme and the balance pay awards and activity volumes. Despite successful recruitment campaigns leading to an increase in whole time equivalents in post, on-boarding processes and activity demands saw our year on year agency costs increase by £2.6m. This was outside of the target set by NHSI.
- Non-pay costs were £8.3m (8.0%) higher than 2018/19 which included £3.4m of additional sub-contracted activity. This included the full year effect of the Urgent Treatment Centre pilot which commenced in November 2018, as well as increased outsourcing of activity as the Trust responded to increased emergency demand. The Trust also saw an increase of £2.3m (24%) in its contribution to the Clinical Negligence Scheme for Trusts.
- The above areas resulted in a decrease in our EBITDA performance of £24.2m (59.8%) year on year, largely due to the decreased income from the Provider Sustainability Fund (£27.7m). The Trust's EBITDA margin was 4.8% compared to 12.1% in 2018/19.

The Trust's health service income exceeded income from the provision of other services, which form only a small part of our total income. Income from other services is used to support health services at the Trust. Further details on income can be found in notes 3 and 4 of the Annual Accounts which follow later on in this Annual Report.

The Trust's cost improvement programme (CIP) saw delivery of £6.6m of savings in 2019/20. Early programme slippage was not recovered as the Trust continued to see a significant increase in emergency activity demand. In addition nationally driven procurement initiatives did not deliver their expected savings. This compares to CIP savings of £9.3m in 2018/19, but nevertheless continues our strong delivery record.

The main elements of the 2019/20 capital programme of £27.3m included:

- The commencement of construction of a new multi storey decked car park to be completed in the Summer of 2020 £7.3m;
- The provision and equipping of a new 33 bedded inpatient ward, 6 bed emergency surgery unit and associated assessment areas £4.5m;
- The purchase of £3.2m of medical and imaging equipment;
- £3.8m of investments at St. Peter's, including expanding the education centre, expanding the urology centre, upgrading the pharmacy robot and refurbishing the department and on a new Stores facility;
- £1.4m of investments at Ashford including creating the new Infusion unit, and reproviding the HR offices;
- £2.4m investment in IT systems and infrastructure;
- £1.0m of backlog maintenance works; and
- £1.4m of enabling works following the sale of land at St. Peter's Hospital in March 2019.

The majority of the capital programme was funded from internally generated resources; however in addition the Trust (i) increased borrowings in the form of finance leases on our Imaging Managed Equipment Service, and (ii) received Public Dividend Capital allocations totalling £4.2m, mainly to fund information technology and in support of waiting list capacity.

Cash balances fluctuated throughout the financial year as the Trust over-performed in activity terms, incurring costs, but did not receive payment for the bulk of this over-performance until the end of the financial year. Prior year surpluses enabled the Trust to invest in the capital programme referred to above. Despite this the Trust still ended the financial year with a cash balance of £53.5m

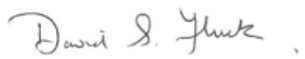
The Trust's financial performance for the whole of the 2019/20 financial year was given an overall finance score of 3, against a plan of 1. The finance score forms part of the Finance and Use of Resources theme in the NHS Oversight Framework, and is scored between 1 and 4, where 1 is 'low risk'. The elements making up this metric are set out in the table below.

Our finance score was mainly driven by having a smaller surplus than expected and through our significant use of agency staff in meeting demand pressures.

		2019/20			2018/19		
Area	**Metric**	**Weight**	**Metric**	**Score**	**Weight**	**Metric**	**Score**
Financial sustainability	Capital Service Cover	20%	2.04x	2	20%	5.48x	1
	Liquidity	20%	54.17	1	20%	69.17	1
Financial efficiency	I&E Margin	20%	0.30%	2	20%	13.50%	1
Financial controls	I&E Margin – distance from plan	20%	-2.20%	4	20%	1.90%	1
	Agency	20%	63.24%	4	20%	36.85%	3
	Weighted score			2.60			1.40
Overall Finance and Use of Resources Rating				**3**			**1**

2020/21 Plan

As a result of the COVID-19 pandemic all operational planning for 2020/21 was halted, and our revenue budgets were set in line with the block and top-up contract arrangements initiated by NHS England and NHS Improvement. As a result of these arrangements we currently expect to break even in 2020/21. Our capital programme continues apace with significant investments in completing the new St. Peter's Hospital multi storey decked car park, improved theatres in Ashford Hospital and on our Electronic Patient Record (EPR).



Dr David Fluck
Acting Chief Executive

29 June 2020

Progress against our strategic objectives

The following section describes our progress against each of our five strategic objectives:

- **Quality of Care**
- **People**
- **Modern Healthcare**
- **Digital**
- **Collaborate.**

Strategic objective 1: Quality of Care: creating a learning organisation and culture of continuous improvement to reduce repeated harms and improve patient experience

Strategic objective 2: People: being a great place to work and be a patient, where we listen, empower and value everyone

Strategic objective 3: Modern Healthcare: delivering the most effective and efficient treatment and care through standardisation in the delivery and outcome of clinical services

Strategic objective 4: Digital: using digital technology and innovations to improve clinical pathways, safety and efficiency and empower patients

Strategic Objective 5: Collaborate: working with our partners in health and care to ensure provision of a high quality sustainable NHS to the communities we serve

Strategic objective 1: Quality of Care

Creating a learning organisation and culture of continuous improvement to reduce repeated harms and improve patient experience

Our key achievements over the last year are:

Dealing with Issues and complaints

From 1 April 2019 to 31st March 2020 we received 471 complaints and concerns and a total of 1891 PALS contacts. This compares to 537 complaints and concerns and 2015 PALS contacts received during the previous year. Our complaints management improvement plan launched last year to improve investigation and turnaround within the 25 day timeframe. This has been extremely successful with 100% of complaints achieving a final response within 25 days. We have a dedicated patient panel which works across various committees on important issues representing the voice of our patients.

Becoming a learning organisation

We have continued to build on our mission to become a learning organisation, focusing on patient experience and addressing patient expectations and anxieties as seen 'through their eyes' using Experience Based Co-design (EBCD) methodology.

Opportunities for our teams to review and improve the services we give to patients continue. Our colleagues attend multidisciplinary serious incident and mortality learning events where they can reflect in an open and safe environment looking at preventing harm to our patients and training needs. Simulation learning at ward level fuelled by learning identified from serious incidents ensures improved safety is implemented by staff in practice.

Improving medication safety remains one of the Trust's top priorities and during Medication Safety Week in July the project team were out in force trying to raise awareness of medication safety issues and provide clinical colleagues with the opportunity to share their feedback and ideas around this important safety initiative. They shared short videos in which colleagues described a medication incident they have been involved with and the learning from this, encouraging honesty, transparency and sharing.

Strengthening our approach to harm-free care

Our ongoing commitment to the reduction of hospital associated harms has been strengthened with the appointment of our new Consultant Nurse in Harms Free Care, the first in the UK. This role brings together the hospital associated harms of falls, venous thromboembolism (VTE), pressure ulcers, catheter-associated urinary tract infections and harm associated with poor nutrition and hydration. The team will link in with community partners to build an understanding around harm in hospital and across our local health system.

Innovation in Quality

We continue to take an innovative and proactive approach to improving the quality of care for patients and the team. Some highlights from the last year include:

New Virtual Respiratory Clinic

As part of the Trust's response to the COVID-19 situation we established a new type of virtual respiratory clinic, named the Respiratory Emergency Department (REED) Clinic. The only one of its kind in the UK, this service reduced the number of patients with confirmed or suspected COVID-19 requiring hospital admission, and facilitated safe discharge of patients no longer requiring oxygen into the community. The success of the clinic in such a short space of time is an indication of the success we are having providing patient focussed care in collaboration with multiple teams across the health system.

Exemplar Status for Interventional Radiology

The Interventional Radiology department based at St. Peter's Hospital was awarded renewal of their Exemplar Status in April 2019 by the British Society of Interventional Radiology Quality Initiative (BSIRQI), an accolade only achieved by 33 NHS Trusts in the country. Exemplar sites are departments that have demonstrated a commitment to the development of high quality Interventional Radiology Services, have enrolled in the BSIRQI programme, and fulfilled the current criteria for award of exemplar status.

Award of prestigious Bliss Charter

Our Neonatal Intensive Care Unit (NICU) was awarded the prestigious Bliss Baby Charter, only the sixth NICU in the UK to receive this accolade. This demonstrates the commitment of the team to provide the highest quality intensive care to sick and premature babies, whilst intertwining a truly multidisciplinary, family centred approach at every stage of care. Bliss is the leading UK charity for babies who need intensive care so are a very well established and respected organisation.

Launch of new 'Arts in Healthcare' Project

Recognising the emerging evidence of the benefit of art in health for patients and colleagues, we have established a new creative arts steering group. They work to provide a positive and healing environment for all, including use of art, sculpture, music, theatre and architectural design.

#Hello my name is… Healthcare Plays

Throughout 2019 we held a series of four healthcare plays for colleagues about different aspects of end-of life care. These explored themes such as finding resilience in the face of bereavement, the complexity of relationships and the loss of long term partnerships.

For the last play we were privileged to welcome Chris Pointon, husband of the late Dr Kate Grainger and co-founder of the '#Hello my name is…' campaign. Chris gave a fascinating and emotional talk about their experiences and to support the campaign we introduced bright, simple, yellow name badges for staff throughout the year.

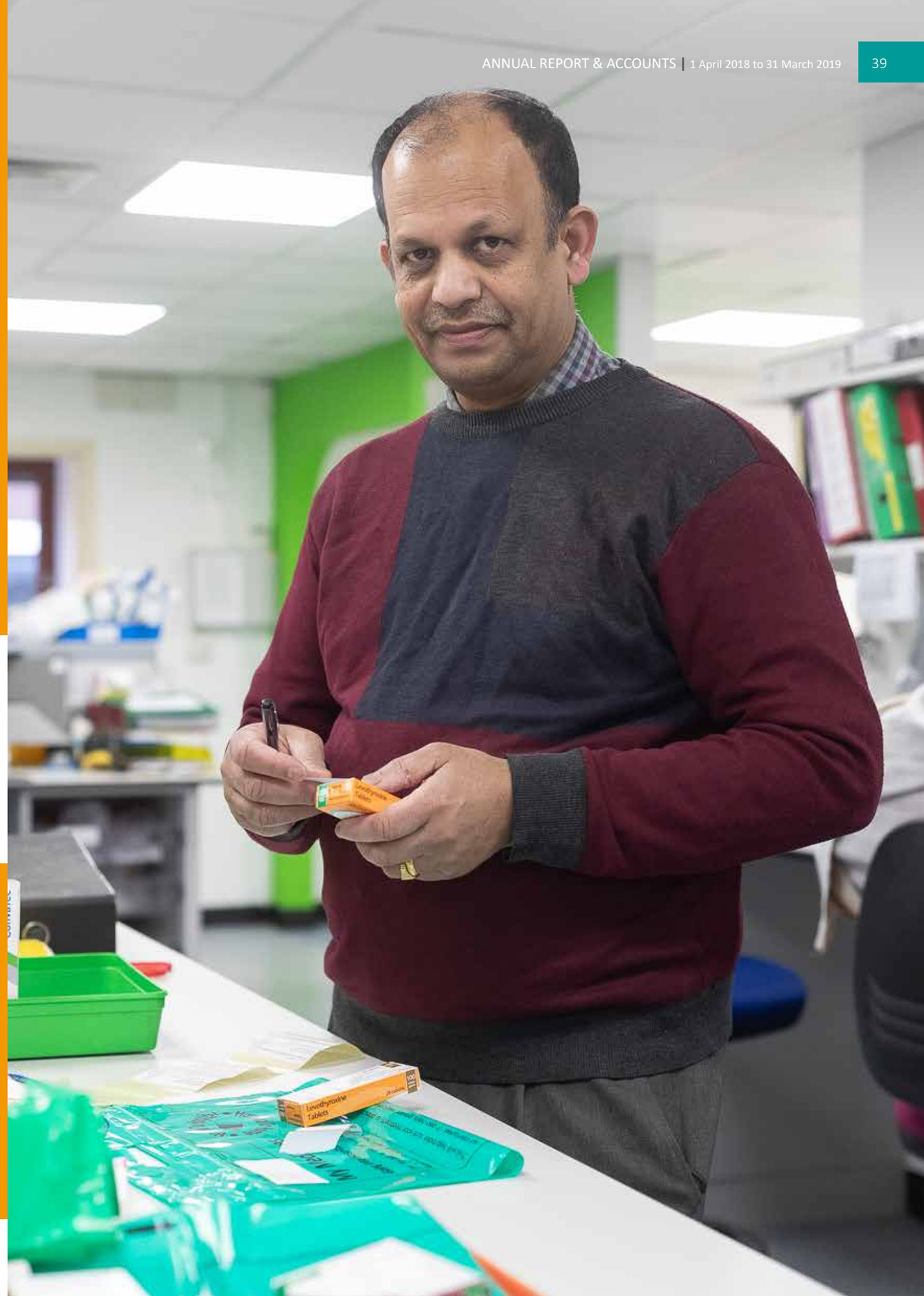
Virtual Clinic Pilot for Musculoskeletal Team

The Physiotherapist Musculoskeletal team started the Attend Anywhere virtual clinic pilot project in October 2019 and this has been successful in reducing the need for patients to attend onsite consultations by over 25% compared to the national average. The system enables patients to attend appointments using video call from wherever they are and feedback from patients has been extremely positive:

Patients using the new virtual clinic service said:

'Consultation was exactly how I thought it would have been face to face'

'a time and facility saving exercise to be commended and should be used to triage all NHS appointments. Well Done!!'



Strategic objective 2: People:

being a great place to work and to be a patient, where we listen, empower and value everyone.

Our key achievements over the last year are:

Delivering against the ambitions of the People Strategy

In 2018 the Board approved a People Strategy to support the delivery of the Trust Strategy Together We Care. The people strategy set a series of ambitious objectives in relation to supply of workforce, vacancy & turnover levels. By March 2020, we had made significant progress in delivering the strategy, such as halving our nursing vacancies, reducing our time to hire metrics, improving our turnover rates and almost eliminating the number of people leaving within less than twelve months. Once again our progress to improve the stability and sustainability of the workforce supply has been a positive contributor when deploying sufficient workforce during the COVID-19 pandemic.

Encouraging the Health and Wellbeing of Team ASPH

Recognising that a well workforce is one which is made up of happy and healthy individuals we continue to further develop the health and wellbeing support in place for colleagues. We have refreshed our offering around six key areas.

We continue to appoint a team of Wellbeing Ambassadors to promote positive mental, emotional and physical health and share information on wellbeing initiatives at the Trust.

Throughout the challenges of the COVID-19 situation this has been more important than ever and we have put a range of extra provisions in place, including enhanced support from the occupational health and chaplaincy teams and the independent employee support service.

Launch of body worn cameras

As part of a plan to prevent and reduce incidents of violence and aggression against staff we have been trialling the use of body warm cameras with teams including security, A&E, intensive care and patient experience. This supports the national NHS Violence Reduction Strategy and 'zero tolerance' approach against incidents of this nature.

Keeping our colleagues safe and enabling them to deliver care and treatment without fear of abuse or harm is an absolute priority and to date use of the cameras is proving to be very successful.

Fun for all the team

One of the undoubted highlights of the year was the first ever ASPH Christmas pantomime. The amount of planning, preparation and dedication from colleagues across the Trust that went into the panto was phenomenal. It all paid off with three, fantastic, sell-out performances and incredible feedback from everyone who attended. We would like to thank St George's school in Weybridge for their support in providing use of their theatre. After such roaring success this will definitely be an event to repeat again!

Keeping Team ASPH up-to-date

We continue to evolve and improve our communications and engagement tools to ensure that all of Team ASPH are up-to-speed and able to engage in meaningful, two way, conversation.

We have held a series of Team Talks throughout the year and are now moving a to virtual method of hosting these – to make it as accessible to as many colleagues as possible, particularly with more working remotely due to the COVID-19 situation.

We have also launched our new Ryalto staff app, which has been well received and installed by a high proportion of colleagues. This enables instant, on-the-go, communication and we are using the app to share a variety of news and messages throughout the day.

Campaign to enable remote working

A key achievement this year was our new guide and move to enabling remote working for colleagues. This very much supports our ambition to be a great place to work and those of the Interim NHS People Plan, calling for Trusts to be excellent, flexible employers and to respond to changing expectations around work, including more demand for flexible working and a healthy work life balance.

Whilst we previously had pockets of very good flexible and remote working practice across the Trust, the new policy makes it much more accessible. Fortunately we had made great progress with this work prior to the COVID-19 situation, which made the move to many more colleagues staying home and working remotely far easier to implement.

Award Winning Employers

In September 2019, Chief Executive, Suzanne Rankin attended the historic Portsmouth Dockyard to receive the silver award in the Employer Recognition Scheme, along with Interim Chief Nurse Andrea Lewis and Richard Wooley, who has supported the Trust's 'Step into Health' programme.

In March 2020, we won the award for 'Collaborative Recruitment of the Armed Forces Community' at the first 'Step into Health' awards. Pictured here, Richard Wooley, Theatre Team Leader, who led the project last year and Colleen Sherlock, Assistant Director of HR, Corporate Services attended a reception at Kensington Place with the Duke of Cambridge prior to the awards ceremony.

Strategic objective 3: Modern Healthcare:

delivering the most effective and efficient treatment and care through standardisation in the delivery and outcome of clinical services

We were also delighted to open a new Infusion Suite at Ashford to accommodate our growing chemotherapy and infusion treatment service. The new suite provides a much better facility with more comfortable and private space for patients receiving these treatments. Being able to provide treatment for patients closer to home to avoid long journeys is a positive development and part of our longer-term strategy.

Our key achievements over the last year are:

Large scale site transformation

Over the last year a large number of transformation estates projects have taken place across the Trust, greatly improving the environment for both patients and the team. The completion of land sales at both sites was a milestone in the history of the Trust and paved the way for major healthcare improvement and to transform services and facilities.

Highlights from Ashford

In December 2019 we officially opened the new children's nursery at Ashford Hospital. The nursery was relocated from the old estates yard and moved to a new, purposed built, facility in the heart of the main hospital building, providing a much improved environment for both children and staff.

Other developments at Ashford included extensive reconfiguration and resurfacing of the main hospital car park and the relocation of the workforce and transport departments to improved accommodation.

Work began on the new multi-deck car park at St. Peter's with the demolition of the old main outpatients' car park in October 2019. The works are now well underway and we look forward to opening the new, much improved, parking facility later this year. The works have caused inevitable disruption to patients, visitors and colleagues and we would like to thank everyone for their patience and support.

Renovation work was completed on the pharmacy, which is much improved and includes a new 'robot' for dispensing medicines automatically.

Building works also begun to create new facilities for intensive care and urology. For intensive care a new waiting room and family room for relatives and visitors is being created. This will replace the current facilities along the main hospital corridor which are very small and provide little privacy. The new urology offices will enable the whole team – clinical and support colleagues – to come together in one place.

In March this year we opened the new Emergency Surgery Ambulatory Care Unit. This provides patients with certain conditions the opportunity to be booked into a 'day case' slot the following day and go home prior to their surgery. This is a better experience for the patient and also reduces demand on inpatient beds.

Works also took place to create a new main store and medical engineering facility at St. Peter's, to replace those lost through the sale of the West Site. The new location within the main hospital building is much better, providing a single point of entry for deliveries.

The Postgraduate Centre restaurant and dining area was extended to provide adequate restaurant facilities for staff following the closure of the Aspects restaurant and prior to the building of a new commercial catering building located at the front of the hospital

Encouraging use of public transport

To encourage greater use of public transport, particularly during the car parking works, we secured additional bus services on the 446 route which runs from Woking to Staines, via St. Peter's and Chertsey. This has been very well received, particularly by colleagues who are able to access the service free of charge.

The transport team also procured larger capacity buses and a wheelchair accessible vehicle to the inter-site Hospital Hopper service between Ashford and St. Peter's. In conjunction with introducing extra passenger services at peak times, this enables more colleagues to use this popular service.

Improved catering facilities

Following a competitive process, OCS (our catering provider) was awarded preferred bidder status for the new catering contract across the Trust with some exciting changes and developments planned to improve the restaurant, café and retail facilities.

Throughout autumn the main entrance and outpatient cafes at Ashford were refreshed and rebranded whilst in October the Abbey Wing café at St. Peter's was completely refurbished and rebranded to 'Proud to Serve Costa Coffee'. Works have also taken place in the Postgraduate Centre restaurant to provide additional serving and dining space for staff.

Transforming physiotherapy services

Over the course of the year the therapies team have undertaken some inspiring work to change and improve the way outpatients receive physiotherapy, including gym-based classes and hydrotherapy.

These services have been relocated to the River Bourne Club in Chertsey, where patients have access to modern, state-of-the-art facilities and equipment. Doing so has enabled us to provide a much better services for patients, with improved exercise equipment and changing facilities – in a 'de-medicalised' environment that helps patients to build confidence in continuing their exercise post treatment.

Therapies into *action*

Quote from a patient: 'I'm writing to thank you for the physio sessions in the pool received for my CRPS. Not only did it have a beneficial effect on my condition but actually made a profound difference to my life. I joined a local health club (and felt confident to do so), lost a stone in weight and feel less daunted doing things on my own now."

Strategic objective 4: Digital:

using digital technology and innovations to improve clinical pathways, safety and efficiency, and empower patients

Our key achievements over the past year are:

Electronic Patient Record Contract

In December 2019 we signed a 10-year contract with Cerner Limited to implement their electronic patient record. This was a substantial procurement exercise run jointly with Royal Surrey Foundation Trust. The preparations for project initiation commenced immediately, centred largely around increasing the significant staff resource required for a programme of this size. The official project start is in June 2020 (delayed slightly due to COVID-19 outbreak), and will take approximately 18 to 22 months to implement. This is due to the data migration from legacy systems and ensuring we map out the changes and improvements to our processes and clinical practice.

Replacing an existing patient administration system with a new electronic record requires a large amount of preparation, but is worth the investment when the benefits are considered. The overall aim is to make our safe hospital safer, and make it easier and safer for staff to provide care.

The suite includes the following modules:

- Patient Administration System and Scheduling
- Patient Flow
- Emergency Department
- Theatres
- Critical Care
- Integrated Electronic Observations

Virtual Clinics

Our therapies department are good early adopters of innovation, digital or otherwise, and so they volunteered to pioneer a national offering of a solution that facilitates virtual clinics (Attend Anywhere). This was fortuitous because in March we found ourselves rolling it out Trust-wide in just two weeks as part of our response to COVID-19.

Electronic Diagnostic Orders

This year we have implemented an electronic ordering solution for diagnostic tests in radiology and pathology. We have done this in conjunction with our pathology partnership service, Berkshire and Surrey Pathology Service (BSPS). We initially worked with GPs so that they could order their tests using the new system, and then rolled it out across the Trust in both inpatient and outpatient areas. The benefits have been in the reduction of paper which in turn increases the accuracy of information and improves the turnaround times of the tests and results.

Patient Level Information Flows

Our information team have worked with our operational teams to provide dashboards that capture live data that can then be used to provide greater insight and support for clinical decisions.

26,263

Non face-to-face consultations

+16.6%

increase in virtual clinics appointments

Strategic objective 5: Collaborate – Sustain and Thrive

Working with our partners in health and care to ensure provision of a high quality, sustainable NHS services to the communities we serve.

Our key achievements over the last year are:

First ASPH Community Day

We welcomed over 300 people to our first Community Day at St. Peter's Hospital on Saturday 6th July. The day was an outstanding success, with visitors of all ages attending and a fantastic buzz created around the Trust.

The feedback from all who attended was brilliant with comments such as 'We're so lucky to have Ashford and St. Peter's in our community – brilliant' and 'Amazing. Well done ASPH!' posted on the visitor comments board.

Interactive stands and activities were set up throughout the hospital for teams to showcase their departments and specialties, including a 'behind the scenes' operating theatre experience, which proved very popular with visitors. The hospital was also supported by various partners including Radio Wey, Surrey Police, South East Coast Ambulance Service, St John's Ambulance, Unison and The Army Reserve and Cadets.

Ashford and St. Peter's Hospitals Chairman Andy Field, Chief Executive Suzanne Rankin, and Col Ash Boreham signed the Armed Forces Covenant, formally marking the Trust's commitment to the serving members of the armed forces as well as veterans and their families.

"The Community Day was absolutely fantastic and a huge success. It was lovely to see families come together to find out more about everything the Trust has to offer. Most people come to hospital when they are unwell or they are visiting someone, so the Community Day provided a rare opportunity to come and see the variety of things that we do and to de-mystify the whole hospital experience." '

Andy Field, Chariman

ASPH as an Anchor Organisation

Last spring we began to work with Well North Enterprises and Lord Andrew Mawson OBE to complete a piece of work to engage with colleagues, local people and key organisations (both public and private sector) to understand how the Trust can become a 'public asset' for the whole community. NHS Trusts such as ASPH have a major impact in their localities purely as a result of their size, and we are looking to use this Anchor Institution status in a positive way to support the health and wellbeing of our community.

The work will help us shape the vision for the investment in our buildings and facilities and also to have a clearer understanding of our future role as a positive 'anchor organisation' within the local area.

In July colleagues from ASPH and the North West Surrey Integrated Care Partnership visited the Bromley-by-Bow Centre – the brainchild of Lord Andrew Mawson who set out 35 years ago to build a place with truly supports individual and community health – recognising that health is primarily driven by social factors and not medical ones. We used this visit to reflect on the opportunities ahead at Ashford and St. Peter's, especially around the redevelopment of our sites.

Well North has also helped us initiative several, exciting, community partnership projects. This includes a close relationship with Stanwell Events and a foodbank with collection points at both Ashford and St. Peter's. We have also provided green space for Surrey County Council to provide training opportunities and work experience to unemployed young adults.

3. ACCOUNTABILITY REPORT

Directors' Report

The Directors present their report for the financial year 1 April 2019 to 31 March 2020, which incorporates a summary of our overall performance against our corporate objectives.

Our Executive Team

Our Executive Team over the last year has comprised:

- **Suzanne Rankin,** Chief Executive
- **David Fluck,** Medical Director
- **Andrea Lewis,** Interim Chief Nurse (from 13 December 2019 – previously Deputy Chief Nurse)
- **Simon Marshall,** Director of Finance & Information
- **Louise McKenzie,** Director of Workforce Transformation
- **Tom Smerdon,** Director of Strategy & Sustainability
- **James Thomas,** Chief Operating Officer
- **Sue Tranka,** Chief Nurse (until December 2019; then commenced a six month secondment with NHS England in the position of Deputy Chief Nursing Officer for Innovation and Safety)

Non-Executive Directors

During the year our Non-Executive Directors have been:

- **Andy Field,** Chairman
- **Mike Baxter**
- **Jane Dale** (joined from January 2020)
- **Chris Ketley**
- **Neil Hayward**
- **Keith Malcouronne**
- **Hilary McCallion** (left end July 2019)
- **Yvonne Obuaya Associate Non-Executive Director** (joined in September 2019)
- **Meyrick Vevers**
- **Marcine Waterman, Deputy Chairman**

More details on our directors are given from p.74 of this report.

Director disclosures

For each individual director currently in post at the time of approval of this report, so far as each director is aware, there is no relevant audit information of which our auditor is unaware.

Each director has taken all the steps that they ought to have taken as a director in order to be aware of any relevant audit information and to establish that our auditor is aware of that information. Each director has also made such enquiries of their fellow directors and of the Trust's auditor for that purpose and taken such other steps required by his/her duty as a director of the Foundation Trust to exercise reasonable care, skill and diligence.

Directors have taken the necessary responsibilities in preparing this Annual Report and Accounts, which have been prepared on a group basis. They consider that the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Remuneration Report

Remuneration & Appraisals Committee and Policy on Remuneration of Senior Managers

The Remuneration Committee consists of four Non-Executive Directors chaired by the Senior Independent Director. The Committee met three times in 2019/20 and attendance is set out on p90.

The Committee sets the policy, and the level of remuneration and terms and conditions of the Executive Directors of the Trust. The Committee receives an annual report on the performance of Executive Directors in the context of strategic objectives which feeds into decisions about remuneration levels. The Committee reviewed the terms of reference this year. Mindful of its duties in managing public funds, in particular as one or more senior managers are paid in excess of £150,000 (the amount set out in guidance issued by the Cabinet Office), its policy is set to balance the need to appoint and retain Executive Directors within the Trust, whilst reflecting a pay range that acknowledges that the organisation is performing well financially. This year it has considered benchmarked information from external sources, and national pay awards granted to staff on the top bands of the Agenda for Change terms and conditions, in aligning the pay award for Executive Directors.

All Executive Directors contracts were open-ended with notice periods for six months. There were no contracts containing a provision for compensation over and above legal entitlement for early termination. In 2019/20 all Executive Directors were paid through the Trust's payroll.

The Nominations and Executive Appointments Committee consists of four Non-Executive Directors chaired by the Trust Chairman.

Remuneration of Chairman and Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is agreed by the Council of Governors following review by its Remuneration and Appraisal Committee. Details of this Committee are set out on p94.

Expenses

In 2019/20 the Trust paid out a total of £6,694 (2018/19- £5,684) in expense payments to 7 (2018/19- 9) Trust Board members and Senior Managers with significant financial responsibility. Further analysis of these expenses by Trust Board member is available on the Trust website at www.ashfordstpeters.nhs.uk/board-member-expenses

The role of Governor of a Foundation Trust is voluntary but the NHS Act and the Constitution states that the Trust 'may pay travelling and other expenses to members of the Council of Governors at rates decided by the Trust'. The Trust has a policy on such reimbursement and this was last approved in November 2019. In 2019/20 a total of £1,794 (2018/19- £836) was paid out in such expenses to 11 (2018/19 – 7) Governors.

Fair Pay Multiple

The Trust is required to disclose the relationship between the remuneration of its highest paid Director and the median remuneration of the Trust's workforce. The calculation is based on the full-time equivalent staff of the Trust at the reporting period end date on an annualised basis.

The banded remuneration of the highest paid Director in the Trust in the financial year 2019/20 was £247,500 (2018/19- £207,500). This was 8.1 times (2018/19 – 7.0) the median remuneration of the workforce, which was £30,401 (2018/19 - £29,608). Total remuneration of the highest paid Director includes salary and benefits-in-kind; it does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The highest paid Director in both years was the Trust's Medical Director who also receives payment for his medical work as a Consultant at the Trust. The pay of the Medical Director is higher in 2019/20 following an increase in programmed activities as well as a payment under the Trust's Employer Pension Contribution Scheme Policy. The policy offers a cash alternative to employer contributions to the NHS Pension Scheme where employees opt out of the NHS Pension Scheme and meet the policy payment critieria.

Salary and pension entitlements of senior managers for the year to 31 March 2020

The tables on the next page set out remuneration and pension benefit details for the reporting period.

A) Remuneration

Name and Title	2019-20 Salary (bands of £5,000)	2019-20 Benefits in Kind (Rounded to the nearest £100)	2019-20 All pension-related benefits (bands of £2,500)	2019-20 Total (bands of £5,000)	2018-19 Salary (bands of £5,000)	2018-19 Benefits in Kind (Rounded to the nearest £100)	2018-19 All pension-related benefits (bands of £2,500)	2018-19 Total (bands of £5,000)
Executive Team	£000	£00	£000	£000	£000	£00	£000	£000
Suzanne Rankin, Chief Executive	180-185	77	-	190-195	185-190	65	-	195-200
Simon Marshall, Director of Finance & Information	140-145	63	27.5-30.0	175-180	135-140	56	25.0-27.5	170-175
Dr David Fluck, Medical Director	235-240	66	-	245-250	205-210	36	-	205-210
Valerie Bartlett, Deputy Chief Executive (to 30 September 2018)	-	-	-	-	70-75	39	0-2.5	75-80
Louise McKenzie, Director of Workforce Transformation	125-130	82	22.5-25.0	160-165	125-130	74	20.0-22.5	155-160
Sue Tranka, Chief Nurse (to 31 December 2019)	95-100	-	22.5-25.0	120-125	125-130	-	125.0-127.5	250-255
Tom Smerdon, Director of Strategy and Sustainability	115-120	77	107.5-110.0	230-235	100-105	68	5.0-10.0	110-115
James Thomas, Chief Operating Officer	135-140	61	30.0-32.5	170-175	100-105	-	35.0-37.5	135-140
Andrea Lewis, Interim Chief Nurse (from 13 December 2019)	35-40	-	-	35-40	-	-	-	-
Chairman and Non-Executives								
Andy Field	45-50	-	-	45-50	45-50	-	-	45-50
Meyrick Vevers, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Prof. Hilary McCallion, Non-Executive Director (to 31 August 2019)	5-10	-		5-10	10-15	-	-	10-15
Neil Hayward, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Prof. Mike Baxter, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Keith Malcouronne, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Chris Ketley, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Marcine Waterman, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Jane Dale (from 1 January 2020)	0-5	-	-	0-5	-	-	-	-

a) Included within the amount of Salary for Dr David Fluck is £195,000 relating to his medical work as a Consultant at the Trust. In 2018/19 this was £163,000 and page 59 sets out the reasons for the increase.

b) Benefits in kind relate to benefits for lease cars (please note that these costs are shown in £ hundreds and not £ thousands in line with NHSI guidance).

c) There were no annual performance-related bonuses paid.

d) There were no long-term performance-related bonuses paid.

e) There were no payments for compensation for loss of office.

f) Non-Executive Directors waive remuneration due for chairing sub-Committees of the Trust Board. No other remuneration was waived by directors, no allowances were paid in lieu and there were no payments in respect of golden hello's.

g) The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

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

B) Pension Benefits

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's Contribution to Stakeholder Pension (to nearest £100)
Executive Team	£000	£00	£000	£000	£000	£00	£000	£000
Suzanne Rankin, Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
Simon Marshall, Director of Finance & Information	2.5-5.0	(2.5)-0	35-40	65-70	552	22	607	-
Dr David Fluck, Medical Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
Louise McKenzie, Director of Workforce Transformation	0-2.5	(2.5)-0	40-45	85-90	638	20	692	-
Sue Tranka, Chief Nurse *(to 31 December 2019)*	0-2.5	0-2.5	25-30	55-60	412	16	461	-
Tom Smerdon, Director of Strategy and Sustainability	5.0-7.5	10.0-12.5	20-25	45-50	303	89	416	-
James Thomas, Chief Operating Officer	0-2.5	0-2.5	25-30	60-65	399	26	438	-
Andrea Lewis *Interim Chief Nurse (from 13 December 2019)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-

Notes:

a) Suzanne Rankin, David Fluck and Andrea Lewis opted out of the NHS Pension scheme in previous financial years.

b) James Thomas opted out of the NHS Pension scheme on 1 July 2019.

c) As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

d) The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual concerned was entitled to a GMP, this will affect the calculation of the real increase in CETV.

*CETVs do not allow for a potential future adjustment arising from the McCloud judgement

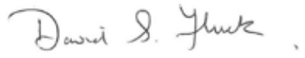
Cash Equivalent Transfer Values

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual concerned was entitled to a GMP, this will affect the calculation of the real increase in CETV.



Dr David Fluck
Acting Accounting Officer

29 June 2020

Staff Report

Analysis of staff costs

An analysis of staff costs is set out in the table below:

	2019/20			2018/19		
	Total	Perma-nently Employed	Other	Total	Perma-nently Employed	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	163,080	144,256	18,824	149,619	132,525	17,094
Social security costs	16,346	14,562	1,784	14,814	13,319	1,495
Apprenticeship levy	798	711	87	727	727	-
Employer contributions to NHS Pension scheme	26,329	23,455	2,874	16,754	15,063	1,691
Employer contributions to National Employment Savings Scheme (NEST)	26	23	3	14	13	1
Termination benefits	-	-	-	-	-	-
Agency/contract staff	16,263	-	16,263	13,634	-	13,634
Total gross staff costs	**222,842**	**183,007**	**39,835**	**195,562**	**161,647**	**33,915**
Recoveries from other organisations	(6,997)	(6,657)	(340)	(3,745)	(3,558)	(187)
Staff costs capitalised	(913)	(913)	-	(669)	(669)	-
Total staff costs	**214,932**	**175,437**	**39,495**	**191,148**	**157,420**	**33,728**

Other staff are those engaged on the objectives of the entity that do not have a permanent employment contract with the Trust. This includes employees on short-term contracts of employment, agency/temporary staff and inward secondments from other entities.

Employer contributions to the NHS Pension scheme in 2019/20 include £7,979,000 (2018/19 £nil) paid directly by NHS England on the Trust's behalf. This follows an increase in the contribution rate for employers of 6.3%.

Average staff numbers

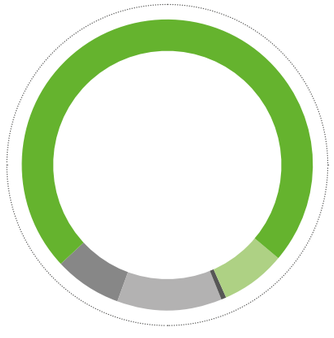
The Trust's average staff numbers in whole time equivalents (WTEs) during the year is shown below:

	2019/20			2018/19		
	Total	Perma-nently Employed	Other	Total	Perma-nently Employed	Other
	No.	No.	No.	No.	No.	No.
Medical and dental	565	565	-	537	537	-
Administration and estates	772	772	-	758	758	-
Healthcare assistants and other support staff	850	850	-	812	812	-
Nursing, midwifery and health visiting staff	919	919	-	872	872	-
Scientific, therapeutic and technical staff	286	286	-	280	280	-
Healthcare science staff	97	97	-	86	86	-
Bank and agency staff	704	-	704	593	-	593
	4,193	**3,489**	**704**	**3,938**	**3,345**	**593**

The total of 4,193 WTE compares to 3,938 WTE for 2018/19. The largest part of our workforce is nursing and midwifery, and medical and dental staff who account for 43% of our permanent employees.

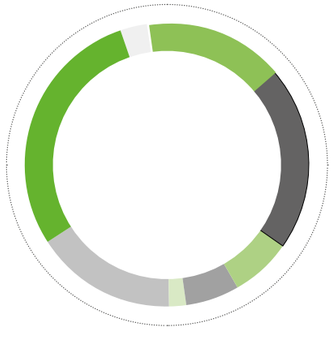
Staff costs 2019/20

Salaries and wages	73.2%
Social security costs	7.33%
Apprenticeship levy	0.36%
Employer contributions to NHS Pension scheme	11.8%
Employer contributions to National Employment Savings Scheme (NEST)	0.01%
Agency/contract staff	7.3%



Staff in Post as at 31 March 2020

Nursing and Midwifery Registered	29%
Add Prof Scientific and Technic	3%
Additional Clinical Services	16%
Administrative and Clerical	21%
Allied Health Professionals	7%
Estates and Ancillary	6%
Healthcare Scientists	2%
Medical and Dental	16%

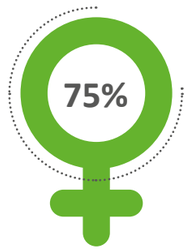


Gender Split

Breakdown at the year end of the number of male and female staff in the following categories:

- Directors
- Other senior managers
- All employees
- By pay band

Gender as % of Total Workforce



Directors

Headcount Numbers			
Gender	Exec	Non Exec	Total
Female	4*	2	**6**
Male	4	6	**10**
Total	**8**	**8**	**16**

*Figure includes Sue Tranka: currently on external secondment

♀ 37.5% ♂ 62.5%

Senior managers

Headcount Numbers			
Gender	Full Time	Part Time	Total
Female	129	61	**190**
Male	59	9	**68**
Total	**188**	**70**	**258**

♀ 26% ♂ 74%

All Perm/FTC staff

Headcount Numbers			
Gender	Full Time	Part Time	Total
Female	1985	1135	**3120**
Male	901	117	**1018**
Total	**2886**	**1252**	**4138**

By pay band

Pay Band	♀	♂
1	70.9%	29.1%
2	78.4%	21.6%
3	85.0%	15.0%
4	85.3%	14.7%
5	85.8%	14.2%
6	85.4%	14.6%
7	28.6%	71.4%
9	77.1%	22.9%
8A	77.6%	22.4%
8B	69.2%	30.8%
8C	57.9%	42.1%
8D	47.8%	52.2%
Med & Dental	50.0%	50.0%
Exec	25.0%	75.0%
Non Exec	62.5%	37.5%
Local	75.4%	24.6%
Grand Total	**75.3%**	**24.7%**

Sickness absence data

NHS sickness absence rates are published by NHS Digital at the following link:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff Policies and Actions Applied During the Financial Year

We have a full range of Workforce policies in place at the Trust. Our Workforce Teams provide support and advice on these policies to both managers and staff. We regularly update and improve our workforce policy and practice, working closely in partnership with staff side to do this. In 2019/20 we reviewed and relaunched the following policies:

- Flexible Working Policy
- Maternity & Fertility Treatment Policy
- New Parent Leave Policy
- Paternity Leave Policy
- Career Break Policy
- Personal and Family Relationship Policy

All of our policies are subject to an Equality Impact Assessment, a practical tool which enables us to identify potential discrimination and take appropriate steps to remove any potential disadvantage for a particular group.

We have in place a guaranteed interview scheme for disabled candidates who meet the essential criteria when applying for opportunities at the Trust. We are member of the Disability Confident Scheme which demonstrates our commitment to recruiting and retaining people from the widest available pool and in particular signals to people with disabilities that we are open and inclusive employer committed to equality in the workplace.

Raising concerns

The Trust is committed to creating a culture where everyone feels able and confident to speak up. This was at the heart of the #RightCulture programme launched in 2014. In addition to accessing advice and support from HR and line management colleagues, the Trust has an active Freedom to Speak Up Guardian (FTSUG). Over the past 12 months, she has appointed ten FTSU Ambassadors, spread across a number of disciplines and levels in the Trust including, Nursing, Maternity Admin, Midwifery, Nurse Educators, Pharmacist, Pain team, Occupational Health, IT and Training. Initial feedback has been very positive with Ambassadors already building constructive open relationships with Divisional Managers and colleagues, where their objectivity and impartiality in dealing with a concern has been invaluable.

OH performance and Flu campaign

The Trust runs an annual flu vaccination programme for staff with a dual purpose of protecting our healthcare workers as well as protecting our patients and members of the public. In 2019/20 we vaccinated 77% of frontline staff, narrowly missing the national target and exceeding our performance from previous years. The campaign was led by our Director of Workforce Transformation, and championed by all of our peer vaccinators including our Chief Executive.

Countering Fraud and Corruption

The Trust is committed to reducing fraud to an absolute minimum. This commitment is fully supported by the Trust Board and monitored on a regular basis by the Trust's Audit and Risk Committee.

To achieve this, we work in partnership with BDO, a professional services firm which provides a dedicated NHS accredited counter fraud specialist (CFS) to the Trust. Our CFS is responsible for fraud awareness across the Trust and the investigation of any suspected or reported fraud activity. This work is supported by regular risk assessments and fraud and bribery prevention techniques. The CFS recently undertook a compliance exercise to assure the Trust Board of compliance against national standards for countering fraud and bribery. In line with NHS Protect's standard for providers, the key aims of our counter fraud strategy are as follows:

- **Strategic governance** - We support and direct anti-fraud, bribery and corruption work through regular monitoring of counter fraud activity at the audit committee, and by promoting adherence to the Trust's fraud policy
- **Inform and involve** - We inform and involve all staff in the promotion, prevention and detection of anti–fraud, bribery and corruption work, ensuring that all are aware of their specific responsibilities in countering fraud, bribery and corruption
- **Prevent and deter** - Where appropriate, we publicise successful fraud, bribery and corruption cases to deter fraud and 'fraud-proof' policies and procedures to reduce the opportunity to commit fraud in high-risk business areas
- **Hold to account** - The Director of Finance and Information will authorise investigations of alleged fraud within the Trust and where appropriate endorse legal sanctions against those who have been found to have defrauded the Trust.

Expenditure on consultancy

During 2019/20 the Trust spent £1,139,000 on consultancy compared to £797,000 in 2018/19. The expenditure was across a number of different areas and projects with the largest area relating to the Trust's transformation programme.

Off-payroll engagements

As a result of the Review of Tax Arrangements of Public Sector appointees published by the Chief Secretary to the Treasury in 2012, the Trust is required to disclose the number of off-payroll engagements at a cost of over £245 per day and which last for longer than six months.

In order to comply with the amended IR35 intermediaries' legislation, and the guidance from NHS Improvement, the Trust notified all contractors that payments for engagements captured by IR35 would no longer be made gross after 31 March 2017 and would be subject to deduction of tax and PAYE at source. As such there were no reportable off-payroll engagements in existence during 2019/20 or as at 31 March 2020 , as all payments are made net of tax and NI contributions, either through the Trust payroll or through the Trust's arrangement with Plus Us and supporting employment agencies.

Disclosures are set out in the tables below.

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

	No
Number of existing engagements as of 31 March 2020	-

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020 , for more than £245 per day and that last for longer than six months.

	No
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	-
Of which:	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	-
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

In accordance with NHSI guidance the Trust supported the review, and implemented the changes, with regard to off-payroll appointments. The Trust's policy on the use of off-payroll transactions in relation to highly paid staff, defined as those at a cost of over £245 per day, is to ensure that all senior level appointments are made through the payroll or through the Trust's arrangement with Plus Us.

In respect of Trust Board members and senior managers with significant financial responsibility, details are set out in the table below:

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	-
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility; during the financial year (which includes both off-payroll and on-payroll engagements)	17

Further details on the remuneration of Trust Board members and senior managers with significant financial responsibility are set out in the Remuneration Report.

Exit packages

Details of exit packages agreed during the year to 31 March 2020 are set out in the following table:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	6	3	9
£10,001 – £25,000	8	1	9
£25,001 – £50,000	18	0	18
£50,001 – £100,000	9	0	9
£100,001 – £150,000	2	0	2
Total number of exit packages by type	43	4	47
Total resource cost (£'000)	**1,830**	**34**	**1,864**

In 2018/19 there were eight exit packages at a cost of £25,000.

The compulsory redundancies in the table above relate from NHS England's award of the HPV Primary Screening Programme for South East and South Central England, to Berkshire and Surrey Pathology Services ('BSPS') of which the Trust is a partner. A number of employees transferred to the Trust, as the host employer, from other NHS organisations under TUPE arrangements. Whilst offers of employment at St Peter's Hospital, where the work is now undertaken, under the same terms and conditions had been made to the affected staff, a number were unable to work at this location due to distances involved. The possibility of suitable alternative NHS employment was the only means identified of avoiding redundancy, given the particular circumstances surrounding this consultation. It was established on an individual basis that neither the Trust nor BSPS would be able to provide suitable alternative employment opportunities, as the locations at which they operate would not be commutable.

The cost of compulsory redundancies in the table above was shared between the partners of BSPS, with the Trust's share being £341,000. The Trust received contract implementation income to fund these costs.

In respect of the non-compulsory departures agreed, all four were contractual payments in lieu of notice.

None of the exit packages were for Board members or senior managers with significant financial responsibility.

Staff Survey

The National Staff Survey provides a yearly snapshot of staff experience at Ashford and St. Peter's Hospitals. Together with feedback from our Staff Friends and Family Test, our real-time feedback tool: PeakOn and our new Employee Recognition Scheme, the survey provides us with evidence to understand the bigger picture, improve the working experience of colleagues and the corresponding experience for patients.

The National Staff Survey was completed by 2003 colleagues between Oct-Dec 2019. This is a response rate of 54%, which is 8% more than previous year (an additional 350 surveys completed). This compares favourably to the average response rate of 51% for acute trusts.

a) Approach to staff engagement

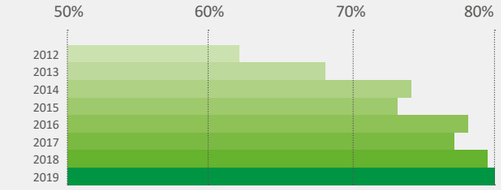
We place great importance on staff engagement and recognise the positive correlation between this and motivation, commitment, involvement in change and ultimately the impact on the quality of patient care.

The Trust has a structured and regular communication process with our employees and their representatives including daily email bulletins, a weekly message from our Chief Executive, monthly blogs from executive colleagues and various formal and informal meetings with staff governors, our trade union colleagues, and other networks. We also have an organisational engagement mechanism 'Team Talk', which is run quarterly and is live streamed so all staff can view.

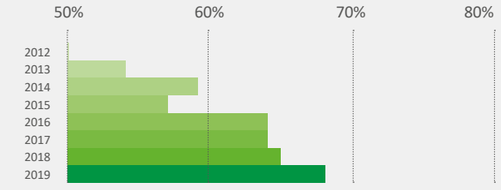
Our staff survey results confirmed that the Trusts engagement score, improved yet again, moving to 7.2/10, which is above the acute sector average, with 7 out of 9 engagement questions improving from last year or maintaining at the same level.

Advocacy

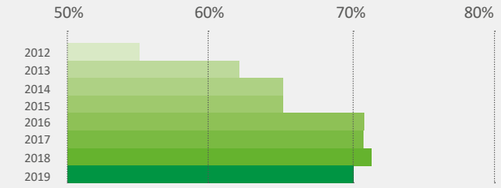
Care of patients/service users is organisation top priority



Would recommend organisation as a place to work

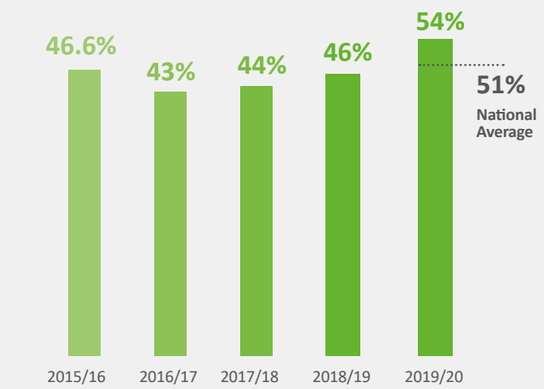


If friend/relative needed treatment, would be happy with standard of care provided by organisation



b) Summary of performance – results from the NHS staff survey 2019

Response Rate



Trust Improvement on last year and above the national average.

The following tables outline the Trust's performance against the ten main indicators for 2017, 2018 and 2019 and how they benchmark against other organisations in our benchmarking group.

	2019/2020		2018/2019		2017/2018	
	Trust	Benchmarking Group	**Trust**	Benchmarking Group	**Trust**	Benchmarking Group
Equality, Diversity & Inclusion	**8.9**	9.0	**8.9**	9.1	**9.0**	9.1
Health and Well-Being	**5.9**	5.9	**6.0**	5.9	**6.2**	6.0
Immediate Managers	**6.8**	6.8	**6.7**	6.7	**6.6.**	6.7
Morale	**6.1**	6.1	**6.0**	6.1	**No available data**	
Quality of Appraisals	**6.2**	5.6	**6.1**	5.4	**5.9**	5.3
Quality of Care	**7.5**	7.5	**7.5**	7.4	**7.5**	7.5
Safe Environment - Bullying and Harassment	**7.9**	7.9	**7.8**	7.9	**7.9**	8.0
Safe Environment - Violence	**9.4**	9.4	**9.4**	9.4	**9.4**	9.4
Safety Culture	**6.7**	6.7	**6.6**	6.6.	**6.6**	6.6
Staff Engagement	**7.2**	7.0	**7.2**	7.0	**7.2**	7.0
Team Working	**6.6**	6.6	**No available data**			

The staff survey shows that our results have remained consistent over a number of years, and it provides us with clear information of where to focus our priorities for the coming year.

It highlights that we are above the national average for themes around Quality of Appraisals and Staff Engagement and that we are at the same level as the national average for Health and Wellbeing, Immediate Managers, Morale, Quality of Safety and Team Working.

We are below the national average for the theme of Equality, Diversity & Inclusion.

c) Future priorities and targets

The Trust will continue with its approach to having Trust wide and directorate level action planning, progress of which are reviewed by the Trust Executive Committee and Equality, Diversity and Inclusion steering group.

The vision for the organisation is to a Great Place to Work, where we Listen, Empower and Value everyone, and this has been a key focus of the 2019/20 workforce transformation programme. Our objectives include creating a clear vision on how the Trust will aim to be a great place to work and identifying ASPH unique selling point, clearly understanding what staff prioritise when choosing an employer and assessing our performance against this.

During 2019/20 we have enhanced wellbeing for staff through implementation of the HWB strategy, we have put in place initiatives to address EDI priorities, to improve psychological safety, inclusion and kindness, and continuing a zero tolerance campaign regarding violence and aggression, and tackling bullying and harassment.

All areas of the staff survey are reviewed and plans are developed, however, specific focus will remain on:

1. **Improving Health and Well-Being** –Health and wellbeing continues to be a key priority of the Trust and in 2020 we will be focusing on the development of a Trust 'Wellness Centre' which will provide staff with a space to exercise, be social and relax.

We have recruited a number of Wellbeing Ambassadors who will receive training to support the organisation in communicating key wellness messages, as well as being the first point of contact for signposting colleagues to resources relating to the six key wellbeing themes:

- Emotional Wellbeing
- Physical Wellbeing
- Financial Wellbeing
- Environmental Wellbeing
- Social Wellbeing
- Cultural Wellbeing

There will be a continued focus on supporting mental health awareness and we will continue to work with staff and managers to ensure flexibility remains in the workplace and working hours are not exceeded.

2. **Continuing to develop the right culture and reduce incidents of bullying and harassment** – Getting this right is a key priority to ensuring that we are a caring, fair and inclusive employer. We will be launching our `Civility in the workplace' campaign to raise awareness of the about the impact of how we treat each at work has on individuals, our teams and ultimately on how we treat and provide care to our patients.

Equality, Diversity and Inclusion

The Trust remains committed to providing services and employment opportunities that are inclusive across all strands of equality; age, disability, gender, ethnicity, race, religion and belief and sexual orientation – in accordance with the Equality Act 2010 and our public sector equality duties.

Our vision is to build leadership for inclusion inside the organisation and in the communities and networks we serve. To foster a healthy, inclusive, compassionate and respectful culture, where every member of the team feels valued and respected and the Trust is a great place to work and to be a patient irrespective of background, colleagues and/or patients feel safe to raise concerns without fear of retribution and we reflect the community we serve, and we role model and encourage others in our position as an anchor institution.

Our equality objectives are linked to the Trust Strategy, the 5 strategic objectives, to ensure that this becomes embedded as part of our core business and structure. These are described in details below.

Quality of Care: Equal access and care delivery: To ensure that the Trust provides fair treatment, fair outcomes and equal access for all our patients.

People: Diverse workforce: To ensure that our workforce is reflective of the community that we serve and is proportionately represented at all levels of the organisation.

Modern Healthcare: To ensure that we have an inclusive environment: where our workplace is inclusive and flexible.

Digital: Equality of opportunity: Ensuring all staff have access to development, utilising technology and digitisation in order to enable all members of the team to achieve their full career potential.

Collaborate: Health equality – Working with our network leads & champions, with our partners and with expert advisors to promote equality and reduce discrimination in the workplace and health inequalities in our outcomes.

Our Equality and Inclusion Steering Committee is chaired by our Chief Executive with membership from our executive team and representation from our BAME, LGBTQ+, Disability and other networks. The networks have an agreed annual work programme which includes celebration of cultural events such as Ramadan and Diwali. We were proud to participate and represent the Trust in the very first Pride in Surrey event in 2019 which also saw collaboration with colleagues across Surrey Heartlands.

Our programme for the coming year will see the launch of the rainbow badge initiative which is a way of showing that we are an open, non-judgement and inclusive place for people that identify as LGBT+ and that we are inclusive of all identities, regardless of how people define themselves. People wearing a rainbow badge will be there to listen, support and to help our patients and staff to seek help if they need it. As part of our disability equality programme, we are launching a campaign to increase disability declaration rates so that the organisation can provide appropriate and adequate support i.e. reasonable adjustment. As part of our inclusion programme, we are fully committed to increasing the representation of BAME (black, Asian, minority, ethnic) staff at senior levels through recruitment and promotion.

Our European Employee Support Programme has been well received and continues to be a source of information, resources and support for staff during this uncertain time. We have supported a large number of staff to apply for the EU Settlement Scheme and continue to do so through a targeted approach.

NHS Foundation Trust Code of Governance

Ashford and St. Peter's Hospitals NHS Foundation Trust recognises that the capability of the Trust Board of Directors and Council of Governors is critical to the success of the Hospitals. Our ability to do what we do, and to do it well, will help us to serve our patients and our community.

The Trust strives to continuously improve its processes, in line with key national guidance, to ensure safe, high quality services for our patients, and to provide a clear framework within which our staff can thrive.

Each year we review our governance arrangements against the provisions of NHS Improvement's Code of Governance which sets the standard for best practice and the following disclosures give a clear and comprehensive picture of the Trust's governance arrangements and how we apply the main principles.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code of Governance or, where it does not, to provide an explanation which justifies departure from the Code in particular circumstances. For the year ending 31 March 2020 the Trust complied with all the provisions of the Code of Governance published by NHS Improvement in 2014.

Board of Directors and the Council of Governors

The Board has agreed a Trust Governance Framework which describes the roles of the Board and the Council. This confirms that the Council will carry out its statutory duties (further detail is given in the section on the Council below) and will be consulted on the Trust's forward plans.

The Board has agreed to meet formally and in public at least six times per year, and consider items under four broad agenda headings:

- Quality and safety
- Performance
- Strategy and planning
- Regulatory

In addition the Board meets in closed session, having published a framework setting out the types of matters normally dealt with in private. These typically include matters relating to individuals or matters of a commercial nature. The Board also meets quarterly in the Strategic Change Committee the primary purpose of which is to provide horizon scanning to inform understanding and assurance on delivery of the Trust strategy, to formulate new and evolving strategy, and to provide oversight, scrutiny and assurance to the Board on the success and impact of the Together We Care Strategy.

The unitary Board of Directors is responsible for ensuring the Trust complies with its License, the mandatory guidance issued by NHS Improvement, its Constitution and relevant statutory requirements and contractual obligations. The Board of Directors sets the Trust's strategic aims, taking into consideration the views of the Council of Governors. The Board of Directors as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust.

The Council of Governors represents the interests of the local community, both members of the public and staff who are Foundation Trust members, and local stakeholders. The Council of Governors is not responsible for the day-to-day management of the organisation which is the responsibility of the Board of Directors, but the Council holds the Board to account via the Non-Executive Directors.

The Board has approved a formal Scheme of Delegation of Authority and Responsibility and within this Scheme there is a Schedule of Matters Reserved for the Board. This Scheme forms an important part of the Trust's system of internal controls.

In the event of a dispute between the Board and the Council a disputes procedure is described in the Constitution.

Composition of the Board

The Board is made up of the Chairman, seven Non-Executive Directors, one Associate Non-Executive Director, and seven Executive Directors. The Trust Board Secretary attends all Board meetings.

The Council of Governors' Nominations & Appointments Committee met on the following dates and endorsed the following recommendations during the year to the Council of Governors for ratification:

- On 13 August 2019: The following changes were agreed subsequent to Hilary McCallion's resignation. Dr Mike Baxter, Chair of the People Committee moved to Chair the Quality of Care Committee and Marcine Waterman, Deputy Chairman was appointed Chair of the People Committee. The Council of Governors had also been consulted on the appointment of Meyrick Vevers to the role of Senior Independent Director.
- On 27 November 2019: The Committee had endorsed the interview panel's recommendation for the Non-Executive Director appointment following consideration of the proposed Appointment Process for a new Non-Executive Director.

Andy Field, Chairman

Andy Field was appointed as Chairman from September 2017 having previously been a Non-Executive Director at Surrey and Borders Partnership NHS Foundation Trust. His career includes 19 years as an Officer in the Royal Corps of Signals where he saw active service, followed by a variety of private sector roles, including Partner in Deloitte, Business Unit Director at Fujitsu, Chief Operating Officer of Tribal Group plc and latterly running his own company focusing on business transformation utilising technology innovation.

As well as his role with us, Andy is Chairman of CSH Surrey, a not for profit community services health provider and Think Learning a private sector business that implements Learning Management Systems.

Andy is Chairman of the Executive Directors' Nominations & Appointments Committee, is a member of the Executive Directors' Remuneration & Appraisal Committee and is a member of the Charitable Funds Committee and the Integrated Digital Committee.

Professor Mike Baxter, Non-Executive Director

Professor Mike Baxter was appointed as a NED in July 2016.

Currently in practice as a private physician, diabetologist and endocrinologist at the Runnymede Hospital, Chertsey, Mike possesses a long and successful track record at Ashford and St. Peter's Hospitals as a previous Medical Director and Deputy Chief Executive.

Through his NHS career Mike displayed his clinical expertise gaining a silver national clinical excellence awards and being recognised by the HSJ a piece of work demonstrating a reduction in hospital admissions from nursing homes.

Mike is currently working within the pharmaceutical industry for Sanofi UK and Northern Ireland as medical therapy expert and continues to lecture and publish in the area of diabetes and diabetes care delivery.

Mike is Chair of the Quality of Care Committee and a member of the People Committee.

Neil Hayward, Non-Executive Director

Appointed in July 2016, Neil has over 25 years' experience working in large and complex businesses in the UK and internationally. He has held a number of executive Human Resources (HR) positions in both the private and public sectors, including at the Post Office, BT, the Ministry of Justice and Serco Group. Neil is currently HR Director, and a member of the Group Executive Team, at High Speed Two (HS2) Ltd reporting directly to Chief Executive Mark Thurston. HS2 has been tasked by the Department for Transport (DfT) with managing the delivery of a new national high speed rail network. It is a non-departmental public body wholly owned by the DfT.

Neil is Chair of the Strategic Change Committee and a member of both the Modern Healthcare Committee and People Committee. Neil also sits on the Executive Directors' Nomination & Appointments and Remuneration & Appraisal Committees

Chris Ketley, Non-Executive Director

Appointed in July 2016, Chris has extensive senior executive experience and a proven track record in delivering commercial, brand and customer value across a variety of industry sectors, including private healthcare, media, financial, motoring and energy services, with a particular focus on leadership in marketing, customer experience management, digital transformation strategy and programme development.

As General Manager of Membership and Marketing at the AA in the 1990s Chris led from inception the six-year development of the AA's acclaimed 4th Emergency Service positioning and marketing campaign, the most successful in its history. He was an Executive Board member and the first Marketing Director for Amazon co uk in 1999 and since then has been an Executive Board member for Zenith Media UK, where he was the founding Managing Director of its digital media communications agency, Zenith Interactive Solutions. He was also Co-Founder of Active Wellbeing, a healthcare brand in rehabilitation and recovery self-help.

Chris has subsequently focused on helping major service corporations with digital transformation consultancy including Aviva, HSBC Commercial Banking, Bupa UK, Vitality Health, BBC and EDF Energy, evolving their business models and ways of working through the development of digital transformation strategies and new change solutions.

Chris is Chair of the Integrated Digital Committee, a member of the Quality of Care Committee and sits on the Patient Experience Monitoring Group. He is also a Non-Executive for the Surrey Heartlands Digital Programme Board and a member of the ePR Joint Committee with the Royal Surrey County Hospital.

Keith Malcouronne, Non-Executive Director

Appointed in July 2016, Keith has a background in accountancy and consultancy with KPMG, specialising in audit and corporate finance internationally. Since then he has developed experience as a Public Sector/NGO Non-Executive Director, particularly with World Vision UK as Chairman of the Finance, Audit and Risk Committee. Alongside his corporate and NGO responsibilities, Keith has board experience in a number of educational and Christian charities including as a Director of the Guildford Diocesan Boards of Finance and Education.

Keith has completed five years as Non-Executive Chairman of TickX Limited, and continues as an Audit and Corporate Finance Partner at the City firm Acuity Professional Partnership LLP.

Keith is Chair of the Audit & Risk Committee, a member of both the Integrated Digital and Charitable Funds Committees and sits on the End of Life Care Steering Group.

Jane Dale, Non-Executive Director

Jane was appointed in January this year and has an extensive and diverse background working within the NHS after joining in 1982 as a student nurse.

After qualifying as a registered general nurse and then midwife, Jane worked in a variety of nursing roles before moving into management as a clinical governance manager for a primary care and community provider and commissioner. After this she was appointed Director of Clinical Care, responsible for pharmacy, primary care and community services.

Jane has a postgraduate masters in Healthcare Management and in 2009 she joined a large integrated Welsh Health Board where she was responsible for overseeing the improvement of quality and safety of services. Jane has also chaired national groups focused on the duty of candour and improving outcomes following complaints.

Jane's last post was Clinical Director for Healthcare Inspectorate, Wales; a National role covering the whole of the country, focusing on inspection, assurance, and improvement across all health service providers in Wales; and has recently co-authored a national report with the Welsh Audit Office and is undertaking further governance review work with the Healthcare Inspectorate Wales.

Jane is a member of the Quality of Care Committee and People Committee.

Meyrick Vevers, Non-Executive Director

Appointed in July 2016, Meyrick has a significant CFO and Commercial Director background across multiple industries including Telecoms, Professional Services, FMCG & Film/TV. Within these industries Meyrick has experience of all aspects of commercial, financial, operational & business transformation within large international listed companies and smaller PE backed organisations.

Aligned to his professional background Meyrick is also an experienced Non-Executive Director in both public and private sectors including being Chair of the Audit Committee for National Archives.

Meyrick chairs the Modern Healthcare Committee, Charitable Funds Committee and in his position as Senior Independent Director chairs the Executive Directors' Remuneration & Appraisal Committee.

Meyrick is also a member of the Audit & Risk Committee, and Executive Directors' Nomination & Appointment Committee.

Marcine Waterman, Deputy Chairman

Marcine was appointed in April 2018 and brings over 30 years' experience in public finance to the role, and is skilled in helping public sector organisations achieve good governance and value for money.

Her early career experience was in American politics, working for the White House and Ernst and Young (USA). The was followed by over 20 years at the UK's Audit Commission in a range of high profile roles, culminating in her appointment as Controller of Audit (Chief Executive). In this role she oversaw the successful closure of the organisation in March 2015, before being appointed as the first Chief Executive of the Single Source Regulations Office (the new economic regulator for defence procurement).

Marcine is also a member of the Central Government Faculty Board at the Chartered Institute of Public Finance and Accountancy (CIPFA).

Marcine is Chair of the People Committee and is a member of the Modern Healthcare Committee, Audit & Risk Committee and Quality of Care Committee. Marcine is also a member of the Executive Directors' Remuneration & Appraisal and Nomination & Appointment Committees.

Yvonne Obuaya, Associate Non-Executive Director

Appointed as an Associate Non-Executive Director in September 2019 as part of the NHS Improvement NExT Director Scheme; Yvonne has over 15 years multi-sector experience in executive leadership and consultancy across mental health, social care, retail, pharmaceuticals and technology.

Her early career was in IT/Management Consultancy where she worked for multi-national companies including Eli Lilly and Rentokil. She then co-founded Curado in 2007, a residential mental health provider where she has collaborated with multiple Clinical Commissioning Groups NHS Trusts, Local Authorities and communities to establish, develop and transform adult community mental health and social care in the South East of England. Yvonne is currently Managing Director at Curado. This post is non-voting and is not remunerated.

Suzanne Rankin, Chief Executive

Suzanne was appointed Chief Executive in September 2014 having joined the Trust in December 2010 as Chief Nurse. Suzanne began her nursing and management career with the Royal Navy, including deployment during the 1990 Gulf War; a spell as Senior Nursing Officer at NATO Headquarters in Lisbon; and Nursing Officer in charge of the 56-bed Trauma and Orthopaedic Unit at the former Royal Hospital Haslar in Gosport, Hampshire.

Suzanne graduated with an MA in Defence Studies including advanced staff and command training from the Joint Services Command and Staff College in 2005.

Suzanne joined the Ministry of Defence in 2008 where she supported and advised the Surgeon General on nursing leadership and professional matters, and spent time in Iraq and Afghanistan. Prior to joining the Trust she was Deputy Chief Nurse for NHS South Central.

Suzanne is a Non-Executive Director on the Health Education England London & South East Local Education Training Board (LETB) representing Surrey Heartlands STP, and is Chair of the Kent, Surrey & Sussex Clinical Research Network.

Dr David Fluck, Medical Director

David studied medicine at St Bartholomew's Hospital, qualifying in 1986, and continued training as a Physician, and then Cardiologist, in London at St Bartholomew's, Guys, The Hammersmith, St Marys and The London Chest. He obtained his MRCP(UK) and Medical Doctorate and was appointed jointly between St George's and St. Peter's in 1996. He was instrumental in developing Interventional Cardiology, Cardiac Pacing and Complex Echocardiography at St. Peter's during the time of the merger between Ashford and St. Peter's hospital. He also later established the Cardiac Institute between Royal Holloway and Ashford and St. Peter's.

He is now a Fellow of the Royal College of Physician; a Member of The British Cardiac Society and the British Cardiac Intervention Society. He held the posts of Honorary Clinical Senior Lecturer at Imperial College of Science, Technology and Medicine 2001- 2006, Postgraduate Tutor from 2002- 2006 and Clinical Lead on the West Surrey Cardiac Network 2005-2008. He became the Clinical Director for Medicine in 2006, and was appointed to Deputy Medical Director in 2010, before being appointed to his current role of Medical Director in 2012. He continues to practice as a Cardiologist and currently holds the role of Medical Director, Caldicott Guardian, Responsible Officer and Director of Infection Prevention and Control.

As Suzanne Rankin was seconded to NHS Test and Trace as their National Director of Containment on 1 June 2020 for a period of three months, the Board appointed Dr David Fluck as the Acting Chief Executive and Accounting Officer during her period of secondment.

Andrea Lewis, Interim Chief Nurse

Andrea Lewis was appointed Interim Chief Nurse from 13 December 2019, taking over from Sue Tranka who joined NHS England on secondment for six months as Deputy Chief Nursing Officer for Innovation and Safety.

Andrea has been successfully working in the Trust for over two years, in the roles of Deputy Chief Nurse-Corporate Services, Associate Director of Operations for Emergency Services and Associate Director of Operations for Theatres, Anaesthetics, Surgery and Critical Care. In each of these roles she has gained a great breadth of knowledge and experience, and formed strong relationships with colleagues across the Trust.

Prior to working at the Trust, Andrea spent twenty-one years in the Army within the Queen Alexandra's Royal Army Nursing Corps, where she worked clinically before taking on a number of healthcare management roles. She has deployed with Field Hospitals to Bosnia and Iraq and latterly was in charge of the UK Military Hospital in Camp Bastion, Afghanistan.

Simon Marshall, Director of Finance and Information

Simon has a degree in Economics and is a Fellow of the Chartered Institute of Public Finance Accountants. Following ten years working with Price Waterhouse Coopers on finance assignments across central government, local government, health, education and charitable sectors he joined the NHS in 2002. Starting as Finance Director for Hounslow Primary Care Trust, Simon moved in 2005 to become the Finance Director for the West Middlesex University Hospital NHS Trust before joining the Trust as Director of Finance and Information in May 2012. Simon is responsible for the finance, procurement, estates, information and technology functions.

Simon also is the Senior Responsible Officer for both the Surrey Heartlands Digital Programme Board and the Cerner EPR Programme.

Louise McKenzie, Director of Workforce Transformation

Louise McKenzie joined the Trust in April 2013. She is a Member of the Chartered Institute of Personnel Development and holds a degree in Public Administration. Louise has worked in the NHS since 1994, in a number of Associate and Director level roles at Guys & St Thomas' NHS Foundation Trust, Bromley Hospitals and South London Healthcare NHS Trust.

In her time at Ashford and St. Peter's Hospitals she has worked closely with colleagues to improve staff experience, morale and reshape the culture – this has been heavily influenced by the Trust's desire to promote curiosity and creativity, empower teams to drive bottom-up change, improve psychological safety and workforce wellbeing.

Under Louise's leadership the Trust has won national Healthcare People Management Awards for two consecutive years in 2017 for Excellence in Employee Engagement, and 2018 for HR Working Smarter. In her previous role she was a member of the London Partnership Forum working with senior NHS managers and trade union organisations on workforce policy implementation and complex change management programmes.

Tom Smerdon, Director of Strategy & Sustainability

Tom was appointed Director of Strategy & Sustainability in March 2019 and leads on strategy development and implementation, both internally at a Trust level and externally. His focus is on developing and transforming our services to meet our strategic objectives in a sustainable way, including how ASPH supports the range of factors that influence our health and wellbeing.

Tom was previously in the role of Director of Operations for Unplanned Care and has managed clinical operations in the NHS at a senior level since 2005, overseeing theatres, anaesthetics and day surgery and later medicine at UCLH. He moved to Great Ormond Street Hospital in 2009 to manage the Surgery Division prior to joining Ashford and St. Peter's in 2013 as Associate Director of Operations for Medicine and Emergency Services.

He has a degree in Geology and MScs in Environmental Management and Healthcare Leadership for Quality Improvement. Prior to joining the NHS Tom held management positions in environmental consultancy and research and learning and education.

James A Thomas, Chief Operating Officer

James was appointed Chief Operating Officer in March 2019 having joined the Trust in 2015 as Associate Director of Operations for Theatres, Anaesthetics, Surgery and Critical Care, and went on to become Director of Operations for Planned Care the following year. James cemented his passion for the NHS through working as a volunteer at his local hospital, whilst at Sixth Form College.

After working as a hospital porter he then went on to join the NHS graduate Management Training Programme working in placements across acute, community, mental health and commissioning organisations in NHS Wales. James first joined Ashford and St. Peter's Hospitals in 2003 as Assistant General Manager for Surgery, and then went on to take progressively senior operational management roles in general hospitals, specialist hospitals and university teaching hospitals across London and the South West, before returning to Ashford and St. Peter's in 2015.

James has a BA (Hon) Degree in Business & Economics, MSc Management of Health & Social Care and is a graduate of the Kings Fund Top Leaders Programme.

Sue Tranka, Chief Nurse

Sue joined the Trust in September 2017 from Buckinghamshire Healthcare NHS Trust, where, as Deputy Chief Nurse, she led a portfolio covering workforce (safe staffing) and education, healthcare governance, quality improvement and non-medical productivity.

Sue is a Registered Nurse, Midwife, Mental Health Nurse and District Nurse with over 25 years' experience and her professional qualifications include an MSc in Clinical Quality Improvement.

Sue is currently on secondment to NHS England for six months as Deputy Chief Nursing Officer for Innovation and Safety.

Significant Commitments of the Trust Chairman

Andy Field is Non-Executive Chairman of Think Learning, Non-Executive Director of Customer Attuned, Chairman of Central Surrey Health Limited, and Honorary President of the North West Surrey Branch of the NHS Retirement Fellowship.

Balance of Board Membership and Independence

The Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees. This conclusion is supported by the results of a skills audit of those in post at February 2020.

The Board has evaluated the circumstances and relationships of individual Non-Executive Directors which are relevant to the determination of the presumption of independence. The Board determines all of its Non-Executive Directors to be independent in character and judgement.

All Non-executive Directors, including the Chairman, have made declarations concerning their independence with the last annual review taking place in October 2019.

Performance evaluation

The Board of Directors recognises that a regular evaluation of its collective and individual director performance is critical to continuous development and high performance. During 2019/20 we have continued to build on the work previously identified in 2018/19 and further examined our development needs in order to collectively improve our performance.

The Board has designed and implemented robust performance evaluation processes, structures and systems in accordance with the Code of Effective Corporate Governance within the public sector and the Guide to statutory duties for NHS Foundation Trust Governors (published by NHS Monitor (now part of NHS Improvement). The Chairman of the Trust undertakes the appraisal of the Chief Executive and the Non-executive Directors. The appraisal of the Non-executive Directors is conducted by the Chairman in accordance with the process agreed by the Council of Governors. The Chief Executive undertakes the appraisal of the Executive Directors.

Chairman

The Senior Independent Director will conduct the Chairman's appraisal process in accordance with best practice in the code of governance, and this will be reported to the Council of Governors at their meeting in September 2020.

In addition the performance of members of the Board is assessed in terms of the following:

- Attendance at Board and Committee meetings
- Independence of individual directors
- An effective contribution to the Board and Committees through the range and diversity of experience and skills
- Strategic decision making and delivery of the Trust's forward plan

The Council of Governors holds the Non-Executive Directors independently and collectively to account for the performance of the Board, and does this through receiving performance information and a process of constructive challenge at Council of Governor meetings and seminars with the Executive and Non-Executive Directors.

Access to the Register of Directors' Interests

Members of the public can gain access to the Register of Directors' Interests on our website or by making a request to the Trust secretary, either at St. Peter's Hospital, Guildford Rd, Chertsey, KT16 0PZ, or via email **asp-tr.board@nhs.net** or on **01932 723110**.

Board meetings

The Board met in open session nine times during 2019/20 and in closed session 14 times during 2019/20 Directors' attendance was as follows:

	End of term of office	Open Board Meetings attended	Closed Board Meetings attended
Non-Executive Directors			
Prof Mike Baxter	October 2021	7 of 9	11 of 14
Jane Dale*	January 2023	2 of 2	4 of 4
Andy Field	September 2020	9 of 9	14 of 14
Chris Ketley	February 2022	9 of 9	14 of 14
Neil Hayward	July 2021	8 of 9	11 of 14
Keith Malcouronne	July 2021	8 of 9	12 of 14
Hilary McCallion**	July 2019	3 of 5	3 of 6
Yvonne Obuaya***	September 2020	5 of 5	7 of 7
Meyrick Vevers	July 2022	9 of 9	13 of 14
Marcine Waterman	April 2021	9 of 9	13 of 14
Name	**End of term of office**	**Open Board Meetings attended**	**Closed Board Meetings attended**
Executive Directors			
Dr David Fluck	Medical Director	7 of 9	12 of 14
Andrea Lewis****	Interim Chief Nurse	2 of 2	4 of 4
Simon Marshall	Director of Finance & Information	9 of 9	14 of 14
Louise McKenzie	Director of Workforce Transformation & Organisational Development	8 of 9	9 of 14
Suzanne Rankin	Chief Executive	9 of 9	14 of 14
Tom Smerdon	Director of Strategy & Sustainability	9 of 9	13 of 14
James A Thomas	Chief Operating Officer	8 of 9	12 of 14
Sue Tranka***	Chief Nurse	5 of 7	6 of 10

*Jane Dale was appointed January 2020

**Hilary McCallion resigned and left the Trust in July

*** Yvonne Obuaya joined as Associate Non-Executive Director in September 2019

**** Andrea Lewis was appointed Interim Chief Nurse in December 2019

*****Sue Tranka was seconded from December 2019

Board Sub Committees

The Board of Directors has the following sub committees:

- Audit & Risk Committee
- Modern Healthcare Committee
- Quality of Care Committee (QCC)
- Strategic Change Committee
- Integrated Digital Committee
- Nominations Committee (Executive Directors)
- Remuneration Committee (Executive Directors)
- People Committee
- Charitable Funds Committee

Audit & Risk Committee

Membership and Attendance

The Audit & Risk Committee is chaired by Non-Executive Director Keith Malcouronne, and includes two other Non-Executive Directors. Internal Audit (BDO LLP), External Audit (Mazars LLP) and the Local Counter Fraud Specialist are all invited to attend the meetings.

Discharging its responsibilities

The Audit & Risk Committee assures the Trust Board that there is an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the organisation's objectives. In addition financial reporting and counter fraud measures are also reviewed. In doing this the Audit & Risk Committee primarily utilises the work of internal audit, external audit and other external bodies. The Audit & Risk Committee approves the annual work plans of internal audit, external audit and the Local Counter Fraud Specialist.

At its meeting in October 2019 the Audit & Risk Committee reviewed and noted three significant audit opinion risks, in terms of their potential impact on our financial statements, as set out below:

- Management at various levels within an organisation may be in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur there is a risk of material misstatement due to fraud on all audits. The risk may be more acute in the NHS sector because of the central pressure within the NHS to report a financial outturn in line with expectations.
- At 31 March 2019 the Trust's Property, Plant and Equipment balance totalled £179million. The Trust will base its disclosures as at 31 March 2020 on the valuation from 31 March 2019, which will be adjusted for the results of known changes arising from the capital programme across the two sites. Changes in the value of Land & Buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Annual Reporting Manual and the Department of Health Group Accounting Manual.
- Revenue and expenditure- auditing standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting leading to material misstatement and means the external auditors are unable to rebut the presumption. For public sector organisations, the same risk applies to the recognition of non-payroll expenditure and contractual obligations. The pressure to manage expenditure, especially when dealing with high cost specialisms that are not specifically funded, increases the risk surrounding fraudulent financial reporting of expenditure.

Policy for Safeguarding External Auditors' Independence

The Council of Governors approved the appointment of Mazars as the Trust's external auditors in December 2018.

Responsibility for Preparing the Annual Accounts

The Chief Executive is the Trust's designated Accounting Officer with the duty to prepare the financial statement for each financial period in accordance with the National Health Service Act 2006.

Modern Healthcare Committee

The Committee is chaired by Non-Executive Director Meyrick Vevers. The Committee includes two other Non-Executive Directors, Director of Strategy & Sustainability and the Chief Operating Officer, the Director of Finance and Information and the Medical Director.

The Modern Healthcare Committee's role is to review the financial and operational performance, position, risks and decision-making of the Trust. It gives assurance to the Board that this process of review is satisfactory and draws matters of importance to their attention

Nominations Committee (Executive Directors)

The Nominations Committee comprises the Trust Chairman, Andy Field, who chairs the Committee, and three other Non-Executive Directors.

The Committee is responsible for appointing Executive Directors including Interim appointments. The Committee is also responsible for ensuring that there is an appropriate balance of skills, knowledge and experience on the Board of Directors, and this includes succession planning taking into account the challenges and opportunities facing the Trust.

Remuneration Committee (Executive Directors)

A description of the work of the Remuneration Committee can be found within the Remuneration Report on p58. Attendance at meetings by its members is set out in the table below. The Committee is chaired by Senior Independent Director, Meyrick Vevers, the Chairman and two other Non-Executive Directors sit on the committee.

Quality of Care Committee

The Committee is chaired by Non-Executive Director Mike Baxter, and includes three other Non-executive Directors, the Chief Executive, Medical Director, Chief Nurse, Director of Strategy & Sustainability and Chief Operating Officer, Chief of Patient Safety, Associate Director of Quality, Chief Pharmacist, and the Divisional Directors.

The Quality of Care Committee has a duty to ensure that the Trust's governance systems, behaviours and processes relating to risk management, clinical and non-clinical governance, the impact of performance on quality and safety, and the achievement of organisational objectives are effective, and provide the Board with the assurance on these duties to enable the Board to govern effectively. The Committee works in association with the Audit and Risk Committee in matters of corporate governance.

People Committee

The Committee is chaired by Non-Executive Director, Marcine Waterman and membership includes three other Non-Executive Directors, the Chief Executive, Director of Workforce Transformation and Organisational Development, Chief Nurse, Medical Director, and Director of Strategy and Sustainability and Chief Operating Officer.

The Committee's role is to provide assurance to the Board on workforce supply and demand, the development and delivery of the Trust's workforce, leadership, organisational development, education and training, equality and diversity and employee wellbeing strategies and a detailed review and challenge of the workforce and organisational development aspects of the Board Assurance Framework.

Strategic Change Committee

The committee is chaired by Non-Executive Director Neil Hayward and membership includes all Board members. The Committee's role is to provide strategic leadership to the Trust and to provide oversight, scrutiny and assurance to the Board on the success and impact of the Together we Care Strategy.

The Committee will also take a longer term view and help to formulate the strategy for the organisation including major service developments, partnerships, mergers and acquisitions.

Integrated Digital Committee

The Integrated Digital Committee is chaired by Non-Executive Director, Chris Ketley and membership comprises the Chairman and one other Non-Executive Director. Other members include the Chief Executive, Director Finance and Information, Medical Director, Chief Nurse, Chief Operating Officer and Director of Strategy and Sustainability. The committee's role is to provide assurance on the Trust's digital strategy, the prioritisation and development of its digital assets, programme of work and partnerships

and to provide oversight of data quality and information security . It also has a role in ensuring staff education in the benefits that technology will bring and the changes needed in work practices and culture for its effective delivery. The committee also keeps under regular review the strategic risks for which it has responsibility.

Charitable Funds Committee

The Committee is chaired by Meyrick Vevers, Non-Executive Director, and membership includes the Chairman and one other Non-executive Director, the Chief Nurse and Director of Finance and Information and two public governors are in attendance.

The Committee is responsible for the overall management of the Charitable Funds and provides strategic direction in accordance with objects and fulfilment of public benefit; and ensures compliance with governing documents, laws and obligations imposed by donors.

The Committee is accountable to the Trust Board (as corporate Trustee) for the proper use of the charitable funds and to the public as a beneficiary of those funds.

Details of Directors' membership of Board sub committees and number of meetings attended are (including formal Council of Governors meetings):

	Audit & Risk Committee	Remuneration Committee	Nominations Committee	Quality of Care Committee	People Committee	Modern Healthcare Committee	Integrated Digital Committee	Strategic Change Committee	Charitable Funds Committee	Council of Governors (in attendance)
Mike Baxter	n/a	n/a	n/a	5 of 6	5 of 6	n/a	n/a	2 of 3	n/a	0 of 4
Jane Dale*	n/a	n/a	n/a	2 of 2	1 of 1	n/a	n/a	1 of 1	n/a	1 of 1
Andy Field	n/a	2 of 2	1 of 1	n/a	n/a	n/a	5 of 5	3 of 3	1 of 2	4 of 4###
David Fluck	n/a	n/a	n/a	3 of 6	2 of 6	3 of 8	4 of 5	2 of 3	n/a	4 of 4
Neil Hayward	n/a	1 of 2	1 of 1	n/a	4 of 6	6 of 8	n/a	3 of 3	n/a	2 of 3
Chris Ketley	n/a	n/a	n/a	6 of 6	n/a	n/a	5 of 5	3 of 3	n/a	2 of 4
Andrea Lewis**	n/a	n/a	n/a	2 of 2	2 of 2	n/a	2 of 2 #	1 of 1	n/a	2 of 4
Keith Malcouronne	4 of 4	n/a	n/a	n/a	n/a	n/a	3 of 3	0 of 3	2 of 2	3 of 4
Simon Marshall	n/a	n/a	n/a	n/a	n/a	8 of 8	3 of 5	3 of 3	2 of 2	2 of 4
Hilary McCallion †	n/a	n/a	n/a	2 of 2	1 of 2	n/a	n/a	0 of 1	n/a	0 of 1
Louise McKenzie	n/a	3 of 3	1 of 1# #	n/a	6 of 6	n/a	n/a	3 of 3	n/a	3 of 4
Yvonne Obuaya	n/a	n/a	n/a	2 of 4	n/a	n/a	n/a	2 of 2	n/a	3 of 3
Suzanne Rankin	n/a	3 of 3	1 of 1# #	6 of 6	5 of 6	7 of 8	4 of 5	3 of 3	n/a	3 of 4
Tom Smerdon	n/a	n/a	n/a	n/a	3 of 6	6 of 8	5 of 5	3 of 3	n/a	3 of 4
James A Thomas	n/a	n/a	n/a	6 of 6	4 of 6	8 of 8	1 of 1	3 of 3	n/a	4 of 4
Sue Tranka ††	n/a	n/a	n/a	1 of 4	2 of 4	n/a	2 of 3	1 of 2	0 of 2	0 of 2
Meyrick Vevers	4 of 4	2 of 2	1 of 1	n/a	n/a	8 of 8	n/a	3 of 3	2 of 2	2 of 4
Marcine Waterman	4 of 4	2 of 2	1 of 1	5 of 6	4 of 4	8 of 8	n/a	3 of 3	n/a	1 of 4

Notes

1. * Jane Dale joined the Trust Jan 2020
2. ** Andrea Lewis was appointed interim Chief Nurse Jan 2020
3. † Hilary McCallion left the Trust end Jul 2019
4. †† Sue Tranka (ST) on secondment from Jan 2020
5. # Andrea Lewis deputised for ST, Chief Nurse
6. # # in attendance
7. ### Andy Field is Chair of the Council of Governors

Council of Governors

How the Board of Directors and the Council of Governors operate

The Board recognises the value and importance of engaging with Governors in order that the Governors may properly fulfil their role as a conduit between the Board and Ashford and St. Peter's Hospitals NHS Foundation Trust's stakeholders.

The Board of Directors is responsible for the effective running of the organisation, whilst the Council of Governors holds the Non-Executive Directors to account for the performance of the Board of Directors. The Council does not delegate any of its statutory decision making to its committees or individual Governors, since the Constitution provides for committees to undertake advisory work only, with all decisions requiring ratification in a general Council meeting.

In addition to the role of listening to, and reflecting back, the views of the membership to the Board and vice versa, the Council of Governors exercises statutory duties enshrined in law. These include the appointment of, and, if necessary, the removal of Non-Executive Directors and determining their remuneration. The Council also appoints an External Auditor and ratifies the appointment of the Chief Executive. The Council approves any changes to the Trust Constitution and any significant transactions the Trust may wish to enter into as defined within the Constitution. The Council has the right to be presented with the Annual Report and Accounts and to be consulted on forward plans being made by the Board. These roles provide a clear context for the Board to run the Trust, the execution of which is achieved through the Chief Executive and the Executive Team.

The Governors have been consulted on the development of the Annual Plan 2020/21 at a workshop held in November 2019. Governors have also been involved in agreeing the priorities for the Quality Accounts.

Understanding the views of the Council and Members

Engagement by the Board with Governors takes many forms. In 2019/20 the constructive working relationship has continued with discussion on a number of matters both in and out of Council meetings. As well as the quarterly Council meetings the Board and Governors also meet twice a year to discuss strategic issues and input into the Trust business plan. The Governors also have two dedicated meetings with the Non-Executive Directors to discuss Trust business and anything they would like further input on.

There are regular seminars and informal meetings open to all Governors and hosted by the Executive Team, Chairman and Chief Executive. All Governors have the support of the Membership and Engagement Manager to help them fulfil their duties.

All Directors are encouraged to attend the Council of Governors' formal meetings. Governors have continued to take up the opportunity to attend the open Board meetings.

Composition of the Council

There are 25 seats on the Council of Governors including:

- 14 public governors covering six constituencies;
- five staff governors covering five staff constituencies; and
- six appointed governors from partnership organisations.

The Chairman of the Board is also the Chairman of the Council of Governors. The Council of Governors appointed Danny Sparkes (Public Governor for Runnymede, Surrey Heath and Windsor & Maidenhead) as the Lead Governor in July 2018.

The Council meets formally four times each year. Details of the membership of the Council and the attendance of Governors are included in the table 'Register of Governors'. Executive and Non-Executive Directors are also invited to attend the Council meetings.

Council of Governor elections were held in October/ November 2019 with all vacancies being filled. Successful candidates were elected for a three term of office from 1st December 2019 to 30th November 2022.

We would like to acknowledge the contribution made by those Governors that came to the end of their maximum three terms or stood down in 2019:

- **Steve McCarthy,** Public Governor for Elmbridge
- **Godfrey Freemantle,** Public Governor for Hounslow, Kingston-upon-Thames and Richmond-upon-Thames
- **Bhagat Singh Rupal,** Public Governor for Hounslow, Kingston-upon-Thames and Richmond-upon-Thames
- **Simon Bhadye,** Public Governor for Spelthorne
- **Brian Catt,** Public Governor for Spelthorne
- **Denise Saliagopoulos,** Public Governor for Spelthorne
- **Keith Bradley,** Public Governor for Woking and Guildford
- **Maurice Cohen,** Public Governor for Woking and Guildford
- **Judith Moore,** Public Governor for Woking and Guildford
- **Sue Harris,** Staff Governor for Nursing and Midwifery staff

Access to the Register of Interests

All Governors are required to comply with the Trust's code of conduct and declare any interests that may result in a potential conflict of interest in their role as Governor of the Trust. Members of the public can gain access to the Register of Governors' Interests which is available on the Trust's website at:

http://www.ashfordstpeters.nhs.uk/what-is-an-ft

or by making a request via the Membership and Engagement Manager at St. Peter's Hospital, Guildford Road, Chertsey, KT16 0PZ, or via email **asp-tr.foundationtrust@nhs.net** or by telephone on **01932 722063.**

Contacting a Governor

Members who wish to contact their Governor(s) can do this via the Membership Office at **St. Peter's Hospital, Guildford Road, Chertsey, KT16 0PZ** or calling **01932 722063**. In addition, a special e-based communication form is available via **www.ashfordstpeters.nhs.uk**

Statutory Council of Governors' Committees

The Council of Governors has two Committees carrying out specific statutory duties. Details are provided below.

Nomination and Appointments Committee

The Nominations and Appointments Committee provides the Council of Governors with independent and objective recommendations in respect of the names of those individuals they consider suitable for appointment as Non-Executive Director to the Board of Directors.

Membership and attendance is given below:

Nominations and Appointments Committee	Meetings attended
Maurice Cohen (Public Governor – Woking and Guildford)	3 of 3
Andy Field (Trust and Committee Chairman)	3 of 3
Godfrey Freemantle (Public Governor – Hounslow, Kingston-upon-Thames and Richmond upon Thames)	2 of 3
Sue Harris (Staff Governor – Nursing and Midwifery)	2 of 3
Chris Howorth (Appointed Governor – The Royal Holloway, University of London)	2 of 3
Steve McCarthy (Public Governor – Elmbridge)	3 of 3

The Committee met three times during 2019 recommending to the Council:

- the re-appointment of the Non-Executive Directors
- the proposed Non-Executive Director appointment process
- the appointment of a Non-Executive Director.

Remuneration and Appraisal Committee

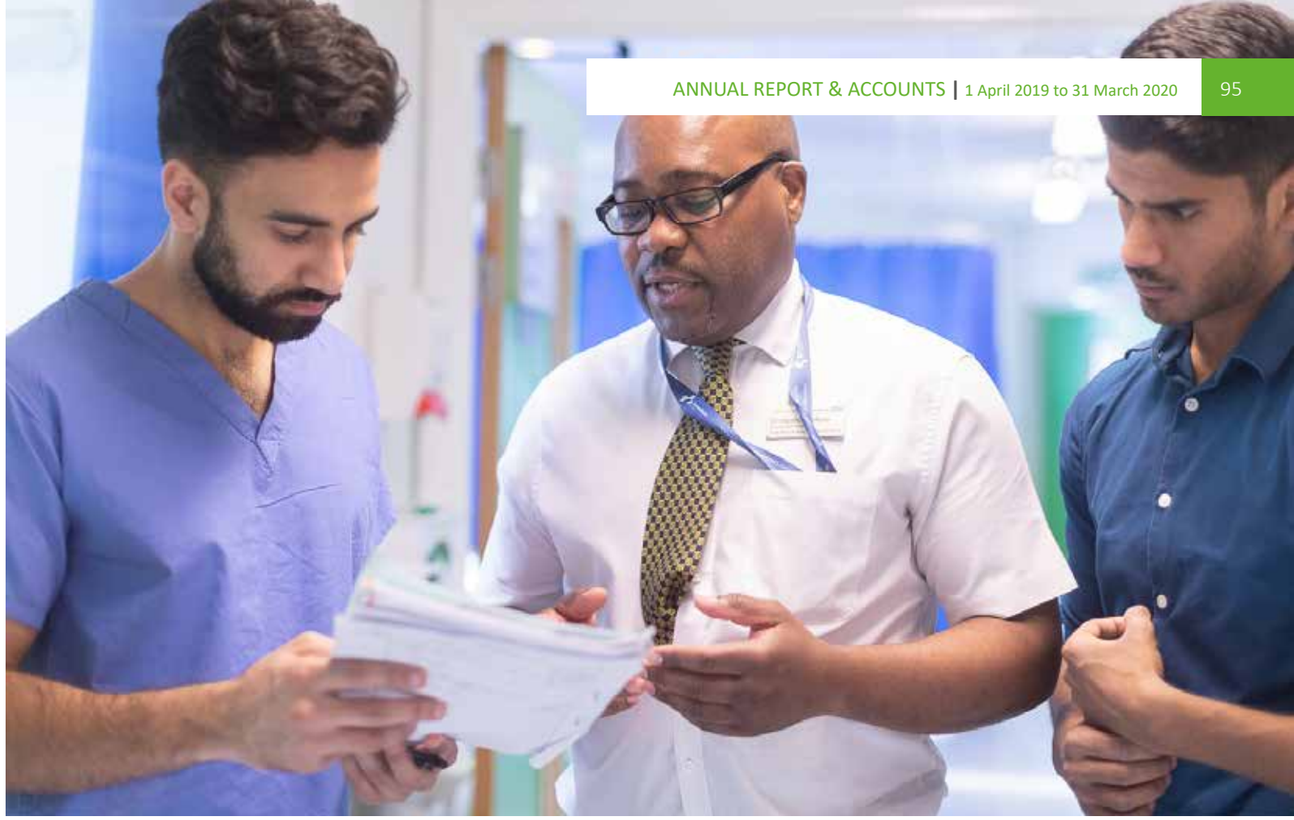
The Remuneration and Appraisal Committee makes recommendations to the Council of Governors concerning the remuneration and terms of appointment of any Non-Executive Director and endorses their appraisals.

The Committee met twice during 2019 recommending to the Council:

- the Chairman and Non-Executive Remuneration
- to approve appraisals of the Chairman and Non-Executive Directors.

Membership and attendance is given below:

Remuneration and Appraisal Committee	Meetings attended
Maureen Attewell (Appointed Governor- Spelthorne Borough Council)	1 of 2
Lilly Evans (Public Governor – Runnymede, Surrey Heath, Windsor and Maidenhead)	2 of 2
Denise Saliagopoulos (Public Governor- Spelthorne)	0 of 2
Danny Sparkes (Public Governor – Runnymede, Surrey Heath, Windsor and Maidenhead)	2 of 2
Matt Stevenson (Staff Governor- allied health professionals, healthcare scientists and healthcare assistants)	2 of 2



Foundation Trust membership

Members fall into two constituencies:

Public Constituency; anyone living in the boroughs of Elmbridge, Guildford, Hounslow, Kingston-upon-Thames, Richmond-upon-Thames, Runnymede, Spelthorne, Surrey Heath, Windsor and Maidenhead and Woking; as well as any borough in Surrey not already mentioned above, can become a member. The Trust has six areas; five of which have two to three elected governors. The 6th area is "Rest of Surrey" and currently does not meet the criteria to have an elected governor.

Staff Constituency; any permanent member of staff, including registered volunteers, can be a staff member. There are five classes which each elect one Governor:

1. **nursing and midwifery**
2. **medical and dental**
3. **ancillary, administrative, clerical and managerial**
4. **allied health professionals, healthcare scientists and healthcare assistants**
5. **volunteers**

Staff are automatically members unless they decide to opt out.

Membership numbers as at 31 March 2020

Public 62%
7,277

Volunteers 3%
324

Staff 35%
4,065

Developing our membership

The Membership and Community Engagement Group of the Council of Governors was set up in March 2011 and leads on developing and implementing the Membership Strategy together with improving communications between Governors and members. The strategy was reviewed in June 2018 and contains targets for membership with a particular focus on areas where we know the Trust needs to develop a more representative membership:-

- To increase membership in the marginally underrepresented areas of Hounslow, Kingston-upon-Thames and Richmond-upon-Thames.
- To increase membership in the 14-16 and 30–39 age groups.

In addressing these priorities, the Trust continues to be mindful of hard to reach groups. Attendance at careers' fairs has taken place to encourage membership from students and job seekers wishing to pursue a career in the NHS. The Group has been keen to encourage membership engagement activities and also considers ways of facilitating two way communications with members. Surveys have been utilised in the past and will continue to feature.

Feedback is encouraged through the Governor Contact form on the Trust's website and via personal communications either written or spoken. The Trust holds a number of Members' Health Events throughout the year which provide a presentation and question and answer session on a number of health-related topics. Events held in 2019 included Dementia Services, End of Life, the Community Day as well as the Annual Members' Meeting where there was representation from Well North Enterprises whom the Trust will be working with to help shape the vision for the future investment in our buildings by engaging with staff, local people and key public and private sector organisations. These health events are extremely popular with members and the Trust receives positive feedback on the content and the opportunity it provides for members to converse with Governors.

Feedback is also welcomed and discussed by Governors who are members of the Patient Experience Group. The Group meets five times a year and the Head of Patient Experience and Involvement /Associate Director of Quality is invited to attend to report on patient experience and also to enable issues and concerns to be raised and appropriate actions taken. The Group also visits departments and wards and meets senior clinical and nurse managers in order to be more effective in sharing the improvement of the patient experience.

Register of Council of Governors - 2019

Name (Constituency / Organisation)	Date elected or appointed	Term of office	Meetings attended
Edwin Addis (Public – Hounslow, Kingston-upon-Thames and Richmond-upon-Thames)	1st Dec 2019	3 years to 30/11/22	1 of 1
Neal Adolphus (Public – Spelthorne)	1st Dec 2019	3 years to 30/11/22	0 of 1
Miranda Alcock (Public – Woking and Guildford)	1st Dec 2019	3 years to 30/11/22	1 of 1
Tom Allan (Staff Governor – Volunteers)	1st Dec 2018	3 years to 30/11/21	3 of 4
Maureen Attewell (Appointed – Spelthorne Borough Council)	1st Dec 2016	N/A	0 of 4
Derek Barnes (Public – Spelthorne)	1st Dec 2019	3 years to 30/11/22	1 of 1
Simon Bhadye (Public – Spelthorne)	1st Dec 2016 (3rd term)	3 years to 30/11/19	3 of 3
Keith Bradley (Public – Woking and Guildford)	1st Dec 2016 (3rd term)	3 years to 30/11/19	3 of 3
Tracey Bradshaw (Staff – Nursing and Midwifery)	1st Dec 2019	3 years to 30/11/22	1 of 1
David Carpenter (Public – Elmbridge)	1 Dec 2019 (2nd term)	3 years to 30/11/22	2 of 4
Brian Catt (Public – Spelthorne)	1st Dec 2016 (3rd term)	3 years to 30/11/19	3 of 3
Iftikhar Chaudhri (Appointed – Runnymede Borough Council)	1st Dec 2018	N/A	2 of 4
Maurice Cohen (Public – Woking and Guildford)	1st Dec 2016	3 years to 30/11/19	2 of 3
Melaine Coward (Appointed – University of Surrey)	1st Mar 2017	N/A	2 of 4
Lilly Evans (Public – Runnymede, Surrey Heath and Windsor & Maidenhead)	1st Dec 2018 (2nd term)	3 years to 30/11/21	3 of 4
Godfrey Freemantle (Public – Hounslow and Richmond-upon-Thames and Kingston-upon-Thames)	1st Dec 2016 (3rd term)	3 years to 30/11/19	3 of 3
Oscar Garcia-Casas (Staff – Medical and Dental)	1st Dec 2018	3 years to 30/11/21	3 of 4
Sue Harris (Staff – Nursing and Midwifery)	1st Dec 2016 (3rd term)	3 years to 30/11/19	3 of 3
Shirley Holmes (Public – Woking and Guildford)	1st Dec 2019	3 years to 30/11/22	1 of 1
Colin Hood (Public – Spelthorne)	1st Dec 2019	3 years to 30/11/22	1 of 1
Chris Howorth (Appointed – Royal Holloway, University of London)	1st Dec 2010	N/A	3 of 4
Deborah Hughes (Appointed – Woking Borough Council)	23rd May 2018	N/A	3 of 4
Hina Malik (Public – Hounslow, Kingston-upon-Thames and Richmond-upon-Thames)	1st Dec 2019	3 years to 30/11/22	1 of 1
Steve McCarthy (Public – Elmbridge)	1st Dec 2016 (3rd term)	3 years to 30/11/19	3 of 3
Chris Marks (Public – Runnymede, Surrey Heath, Windsor and Maidenhead)	1st Dec 2018	3 years to 30/11/21	4 of 4
Sinead Mooney (Appointed – Surrey County Council)	1st Aug 2018	2 years 8 months to 4/05/21	2 of 4
Judith Moore (Public – Woking and Guildford)	1st Dec 2016 (3rd term)	3 years to 30/11/19	2 of 3
Helen Pernelet (Public – Elmbridge)	1st Dec 2019	3 years to 30/11/22	1 of 1
Bhagat Singh Rupal (Public – Hounslow and Richmond-upon-Thames and Kingston-upon-Thames)	1st Dec 2016 (2nd term)	3 years to 30/11/19	3 of 3
Julian Ruse (Staff – Administrative and Clerical, Managerial and Ancillary)	1st Dec 2018	3 years to 30/11/21	3 of 4
Denise Saliagopoulos (Public – Spelthorne)	1st Dec 2016 (2nd term)	3 years to 30/11/19	2 of 3
Michael Smith (Public – Woking and Guildford)	1st Dec 2019	3 years to 30/11/22	1 of 1
Danny Sparkes (Public – Runnymede, Surrey Heath and Windsor & Maidenhead)	1st Dec 2018 (3rd term)	3 years to 30/11/21	4 of 4
Matthew Stevenson (Staff – Allied Health Professionals, Healthcare Scientists)	1st Dec 2019 (2nd term)	3 years to 30/11/22	4 of 4
Roberta Swan (Public – Elmbridge)	1st Dec 2019 (2nd term)	3 years to 30/11/22	2 of 4

Single Oversight Framework

NHS Improvement is the official regulator of Foundation Trusts.

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

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

Segmentation

The Trust has a segmentation rating of '2'.

This segmentation information is the Trust's position at 25 May 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2019/20 score				2018/19 score			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	2	2	1	1	1	1	1	1
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E margin	2	3	1	1	1	1	1	1
Financial controls	Distance from financial plan	4	4	1	1	1	2	2	1
	Agency spend	4	4	4	3	3	3	3	3
Overall scoring		3	3	3	1	1	2	2	1

VEHICLES AND TRANSPORT

1,500

CLEANER JOURNEYS

20

TONNES

EMISSIONS AVOIDED

16.6%

RISE IN VIRTUAL CLINICS

Sustainability Report

In line with our Anchor-organisation principles, we recognise our responsibility to have a positive environmental and social impact on our community around us. We continue to work to minimise our waste and energy consumption, improve our green spaces and bring social value into how we conduct business.

Buildings and estate

Our estates and facilities teams maintain and improve our 2 hospital sites of more than 87,000 square metres of internal floor space; equivalent to over 12 football pitches, based in nearly 29 hectares of grounds. Over 70% of this is clinical space, devoted to delivering direct patient care.

The NHS overall aims to reduce carbon emissions by 34% from 2008 levels, and ASPH has been working on this by reducing vehicle miles where possible, minimising our energy usage (electricity and gas) and minimising waste. Our CO2 emissions have stayed the same as last year due to the Trust's site wide development and modernisation programme. However, closure of the west site at St. Peter's has removed much of our oldest estate that leaked heat and energy. A new modern ventilation plant has been installed at St. Peters to further contribute positively to our environmental impact.

Vehicles and transport

In 2019/20 particular effort has been focussed on reducing vehicular emissions from staff cars and transport and patient journeys to our hospital sites. The funding of free staff travel on the White Bus from Woking resulted in more than 1500 journeys per week being made by staff on the bus instead of driving, which equates to approx 8.4 tonne CO2 emissions avoided. The upgrading of the Inter-site Shuttle to 22 seater PRM (Persons with reduced mobility) compliant vehicles resulted in 3800 additional journeys between St Peters and Ashford hospital between October and December 2019 alone, equating to more than 20 tonnes of emissions avoided.

Work continues with the launch of virtual clinics at the end of the year to provide consultations to patients in their own homes, thereby reducing travel to our sites. In 2019/20 we saw a 16.6% rise in activity like consultations being delivered without the patient needing to leave their home or place of work to come to one of our sites. In addition we have piloted moving traditionally hospital based physiotherapy clinics to River Bourne Gym in Chertsey; a great success which reduces the impact of patient travel to the hospital site as well as embedding services within the communities we serve.

Single Use Plastics

During 2019-20 we signed the NHS Single Use Plastics Pledge, a national initiative intended to dramatically reduce the amount of single use plastics in hospitals. We used 118,650 less pieces of disposable plastic than last year; an 18% reduction in plastic cups, spoons, and straws, replacing them with cardboard food containers and cups, paper straws and wooden stirrers, combined with increasing reusable cutlery in our food outlets. Work is ongoing to make a more significant impact on single use plastics in 2020/21 by considering procurement and packaging alongside potentials for recycling of plastics.

The trust is also now considering 'social value' issues with procurements, for example writing environment issues like plastics usage into contract KPIs and placing a higher value on suppliers' environmental and social-value added to local communities.

Future ambitions

With exciting site developments taking place, plans are in place to work with local partners and charities to design and develop our green areas with more trees to increase the level of nature and improve the sense of wellbeing for our visitors and staff.

In 2020/21 we will continue to work to make more impact on our sustainability and environmental impacts to:

- Reduce single use plastics
- Reduce overall waste sent for incineration
- Increase proportion of our waste that is recycled
- Achieve a reduction in our total carbon footprint by 34% from 2008 levels
- Improve our green spaces to be filled with nature
- Plant trees to clean the air

SINGLE USE PLASTICS

WE USED

118,650

LESS PIECES OF DISPOSABLE PLASTIC LAST YEAR

THAT'S AN

18%

REDUCTION

WE AIM TO ACHIEVE A REDUCTION IN OUR TOTAL CARBON FOOTPRINT BY

34%

WE AIM TO IMPROVE OUR GREEN SPACES TO BE FILLED WITH NATURE

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Ashford and St. Peter's Hospitals NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Ashford and St. Peter's Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Ashford and St. Peter's Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

Dr David Fluck
Acting Chief Executive

29 June 2020

Annual Governance Statement 2019/20

Scope of responsibility

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

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 Ashford & St. Peter's Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Ashford & St. Peter's Hospitals NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk Management is a corporate responsibility and the Trust Board has ultimate responsibility for ensuring that effective processes are in place. The Trust Board is committed to the continuous development of a framework to manage risks in a structured and focused way in order to protect patients, staff and the public from harm and to protect the Trust from losses or damage to its reputation.

The risk and control framework

This section outlines the key ways risk management is embedded in the activity of the Trust, the main elements of the Trust's quality governance arrangements, performance information assessment and assurance regarding CQC compliance monitoring. Also outlined is how the Trust assures the validity of its Corporate Governance Statement. Specific disclosures on the pension scheme, equality and diversity, and climate change follow.

Risk Management

The Trust's approach to risk for the year 2019/20 is detailed in the Risk Management Strategy and sets out our systematic approach to achieving effective enterprise risk management strategically, operationally and culturally. We aim for all our staff to understand and act proactively so that we maximise our success going forward and minimise things going wrong for our patients, staff and stakeholders. Senior managers and Directors are trained in risk management on joining the organisation and subsequently in accordance with the Trust's Mandatory Training Policy. This strategy aligns with the Trust Strategy.

In 2019/20 the Trust appointed a Corporate Risk Manager to ensure a robust training program for managers of all levels of the organisation who have a responsibility to manage their local risks and to facilitate and promote an environment where proactive risk reporting identifies perceived or real threats to patient safety. Each division maintains a risk register and key risks are escalated for inclusion in the corporate risk register, which is reviewed monthly.

The Trust's Risk Management Strategy outlines the building blocks for managing risk and the way in which our risk profile will be incorporated in the Corporate Risk Register. Oversight of the Corporate Risk Register is undertaken by the Trust Executive Committee which is chaired by me and submitted to Trust Board via the Audit and Risk Committee for scrutiny and assurance purposes.

As part of the Trust's approach to risk management each sub-board committee has agreed their risk appetite to be exercised in relation to the strategic objective for which it has oversight and is documented within the Board Assurance Framework (BAF) and is a standing item on Committee agendas. The Board Assurance Framework provides the means of assuring that the Trust will achieve its strategic vision and mission and has oversight by the Audit & Risk Committee.

The Board Assurance Framework is reviewed at the Audit and Risk Committee on a quarterly basis.

The Trust has sought to learn and share good practice through rigorous assessment of the Corporate Risk Register and to cascade this information both to and from relevant Divisional teams through constructive challenge, training and support. Divisional risk management is through Divisional Boards and Governance Meetings with exception reporting to the Risk Scrutiny Committee.

All Divisions monitor their quality and financial risks regularly within each divisional governance framework and are reviewed on a quarterly basis at Risk Scrutiny Committee and high scoring risks are recorded on the Corporate Risk Register which is reviewed at the Trust Executive Committee each month. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to risks identified. The Trust's strategic framework is based on five key strategic objectives: quality of care, people, modern healthcare, digital, and collaborate. Each sub-board committee decide, taking into account the grading of each risk, whether it is appropriate to tolerate, transfer, terminate or treat the risk. The rating for each risk will be matched to a certain level of management within the organisation.

Key Issues and Risks

During 2019/20 each sub-committee has regularly reviewed at each meeting, the key risks associated with the Strategic Objective for which the committee has responsibility to deliver. This regular detailed review includes scrutiny of the risk controls and an analysis of associated key performance indicators in order to gain assurance as to the effectiveness of controls thereby informing any changes to risk scoring. The fully refreshed Board Assurance Framework takes into account both external and internal factors and uncertainties, as part of our risk management process and as such we have identified the following key risks to our strategic objectives which are summarised below:

Strategic Objective: Quality of care

1.1 Failure to achieve avoidable mortality and safer more efficient patient care through an inability to deliver: The priority quality improvement and transformation programmes (Learning from Deaths, medication and infection control strategic improvement programmes) due to insufficient capacity and capability.

1.2 Failure to improve and achieve outstanding patient experience through an inability to harness and optimise learning from patient and family feedback due to insufficient capacity and capability.

Strategic Objective: Modern healthcare

2.1 Non-delivery of the annual operating plan may lead to loss in productivity / efficiency and financial standing.

2.2 A failure to maintain the Trust's physical environment and clinical infrastructure, may lead to clinical pathway difficulties, deteriorating patient and staff experience, patient safety, and health and safety risks.

2.3 A failure to deliver constitutional and operational targets leading to increased patient delay, poor patient experience, increased patient safety risks, increased outsourcing or activity and corresponding loss in productivity / efficiency.

Strategic Objective: Digital

3.1 The Trust's service delivery may be compromised if the current strategy to exploit the electronic patient record fails.

3.2 Failure of key IT systems leads to patient safety, experience or quality risks, data security breaches or process delays.

Strategic Objective: People

4.1 Inability to align workforce supply, to meet current and future acuity and demand, resulting in a misalignment with both the service and financial plan.

4.2 Inability to recruit and retain leading to a poor staff and patient experience.

4.3 Individuals and teams do not feel listened to, empowered and valued resulting in a negative impact on staff and patient experience.

Strategic Objective: Collaborate

5.1 Insufficient capability and capacity to deliver the strategy programme (i.e. the strategic objectives) in accordance with the operating plan so that effect is diminished and/or service sustainability is significantly challenged.

5.2 External factors such as decisions taken by national, ICS, ICP impact our delivery or attempt to counter our objectives or undermine our service sustainability.

5.3 Desired effect of the strategy does not realise the intended benefits to quality and sustainability of patient care.

5.4 Effective external relationships established do not sustain.

Corporate Governance Statement

The Trust obtains assurance regarding its Corporate Governance Statement via internal audit, review by the Audit and Risk Committee and via an external audit opinion.

Our core quality assurance committees are Quality of Care Committee (QCC) which reports to Board, the Quality Governance Committee (QGC), and the Clinical Effectiveness and National Audit Review Group. Divisional and Specialty Boards report into this structure.

Performance monitoring

Compliance with, and delivery of, the quality indicators within Trust contracts is actively monitored at Board and through QCC, QGC, and supporting Divisional and Specialty Boards. Operational performance is overseen at monthly Performance Committee, Specialty Boards, and in Divisional Governance Forum. The Clinical Quality Review Meeting considers the quality impact of the contract by exception.

Data quality and information security updated

The Trust was nearing completion of the Data Security and Protection Toolkit (DSPT) in March when the COVID-19 outbreak halted the final steps required. Work has now recommenced to ensure full compliance, specifically in terms of the mandatory Information Governance training element. The deadline for the DSPT has been reset to 30 September 2020 but the Trust is aiming to submit its return ahead of that date (early July).

The Trust has been working with Templar Executives, who have been provided by the NHSD Cyber Security Centre as part of an offer to provide Trusts with support for their cyber security plans. Templar are supporting us with our action plan to gain Cyber Essentials Plus accreditation, and involves ensuring that not only are our policies in line with the requirements, but that our organisational culture has a golden thread of cyber security consciousness running through it, from Trust Board to individual responsibility level.

CQC compliance

The Quality of Care Committee (QCC) monitors the Trust's assurance activities in respect of its registration with the Care Quality Commission (CQC) and receives information from divisional governance reports. CQC compliance is assessed using a variety of mechanisms including self-assessment against the Regulations through the Domains in Clinical Practice Audit, Mock CQC Inspection, internal audit and divisional governance monitoring.

The Trusts overall CQC rating is unchanged and remains 'good'. The rating combines Trust level quality ratings of safe, effective, caring, responsive and well-led with the NHSI assessment of the Use of Resources. Each registered site receives its own rating and Ashford Hospital was rated as ''requires improvement' and St. Peter's Hospital received 'good'. The latest Trust and site report was published 4 October 2018.

Areas subject to our CQC improvement action plan are two major transformation programmes in the Emergency Department to strengthen the unplanned care pathway and outpatient service development at Ashford Hospital as part of a wider outpatients improvement programme across the Trust. Other minor improvement areas continue to be regularly monitored to ensure ongoing compliance with CQC standards.

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

Register of Interests

The Trust has published on its website an up to date register of interests including gifts and hospitality, for decision making staff within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

NHS Pension Scheme

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

Equality, diversity and human rights legislation

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

Climate Change

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCIP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The resources of the Trust are managed through various measures, including an established and tested budgetary control system, the consistent application of internal financial controls and effective procurement and tendering procedures.

The Modern Healthcare Committee is a sub-committee of the Trust Board chaired by a Non-Executive Director. It reviews operational performance, workforce and finance reports as well as specific update reports against the Service Level Reporting, Cost Improvement Programme, Getting it Right First Time, Model Hospital and Capital Investment agendas. The Trust Board obtains assurance from the Modern Healthcare Committee in respect of all aspects of economy, efficiency and effectiveness, of financial and budgetary management and the use of Trust resources.

Each Division has a Divisional Director, who is a clinician and is actively involved in the business and devolved financial management of clinical services. Divisional scorecards are used to assess each Divisions performance at a specialty and ward level, and these are reviewed at performance reviews held with Executive Directors.

The Trust has continued to use and further develop Service Line Reporting (SLR) and Patient Level Costing during the year and there are clinical specialty leads within Divisions amongst whose responsibilities is the use and review of this data. These leads attend the performance reviews where SLR data and other benchmarking data is also discussed.

Business cases and the financial evaluation of new investments are reviewed on a monthly basis, with subsequent approval by the Commercial Group, Trust Executive Committee, Modern Healthcare Committee or Trust Board according to the Scheme of Delegation. Service line information is used in support of clinical business cases.

Our Internal Auditors include value for money considerations in their audit scope and action points.

Information Governance

Information Governance Assessment

In April 2018 the new Data Security and Protection Toolkit (DSP Toolkit) replaced the Information Governance Toolkit (IG Toolkit). The DSP Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's (NDG) 10 data security standards.

All organisations that have access to NHS patient data and systems must demonstrate compliance with the standards set out in the DSP Toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. Progress is monitored by the Information Governance Steering Group.

Data Security & Protection Toolkit Self-Assessment Outcome

The submission date for 2019/20 DSP Toolkit has been extended to September 2019/20 in order to enable orgainsations to focus on their COVID-19 response. However, the Trust has completed its self-assessment and plans to submit this in June 2020 to confirm it has met all required standards.

Information governance personal data breaches (including data losses)

All Trust staff have a duty to report incidents such as breaches of confidentiality, however minor, so that lessons can be identified and used to inform future practice. All information-related incidents reported in 2019/20 were assessed in accordance with NHS Digital's guidance:[4]

The General Data Protection Regulation (GDPR) as implemented by the UK Data Protection Act 2018; introduced a duty on all organisations to report certain types of personal data breach to the Information Commissioner's Office (ICO) within 72 hours. This applies to breaches where it is "likely to result in a high risk of adversely affecting individuals' rights and freedoms". In addition, there is now a legal obligation to communicate these breaches to those affected without undue delay.

Grading the personal data breach

All incidents are graded according to the significance of the breach and the likelihood of those serious consequences occurring. Above a certain grade incidents are reportable to the Information Commissioner's office and the Department of Health and Social Care with the most significant requiring notification within 24 hours.

Reported breaches

Breaches from 2018/19 are reported below:

Breaches reported on to DATIX	95
Breaches reported on to the DSP Toolkit (since 1st April 2019)	12
Breaches reported to the ICO (via the DSP Toolkit)	3

4. NHS Digital's "Guide to the Notification of Data Security & Protection Incidents", Version 1.3 – September 2018; https://www.dsptoolkit.nhs.uk/Help/29

Incidents reported to the Information Commissioner's Office

The Trust reported 3 incidents to the Information Commissioner's Office:

Date of incident (month)	July 2019
Nature of incident	Breach of patient confidentiality
Nature of data involved	A patient attending an appointment was able to view the appointment schedule including the names of other patients attending that day. By doing so they were able to identify one of the names on the list as their work colleague. The patient went onto relay confidential information to their employer about their colleague.
Number of data subjects potentially affected	1
Notification steps	ICO notified and recommendations completed. Remedial steps taken were that the surgery has now provided a computer for the midwives to use in their room. The midwives now only use the patients' hospital number in order to limit the amount of identifiable information that could potentially be viewed if ever an incident like this occurs again. A redacted version of this incident has been used as an example in the Trust's Information Governance training presentation in order to remind staff about the importance of keeping information confidential.
Information Commissioner's Office (ICO) recommendations	On 29 August 2019, the ICO responded with the following: " We have considered the information you have provided and we have decided that no further action by the ICO is necessary on this occasion. This decision is based on the information we have recorded about the breach. If you believe that any of the information we have recorded is incorrect you should tell us as soon as possible. The reasons for our decision are as follows: • You have not made any reports of any significant detriment towards the affected data subject. • Although the individual was able to view this information, they took it upon themselves to further disclose the information to their workplace, which then caused upset for the affected data subject • This appears to have been an isolated incident caused by 1 member of staff, possibly due to human error."

Incidents reported to the Information Commissioner's Office

The Trust reported 1 incident to the Information Commissioner's Office:

Date of incident (month)	December 2019
Nature of incident	Breach of confidentiality
Nature of data involved	Staff member shared sensitive personal information regarding a patient with another patient they are close friends with.
Number of data subjects potentially affected	1
Notification steps	ICO notified and recommendations completed. Remedial steps taken are that the remit of the original investigation has been widened to include this incident. All staff have been reminded that they should only be accessing personal data when there is a business need to do so, and about the importance of maintaining patient confidentiality. As part of the Aspire message, staff were also reminded of the consequences they may face if they share information without a lawful basis to do so. The Trust has recently reviewed its policy around accessing records to ensure that prominent and sufficient practical guidance is provided.
Information Commissioner's Office (ICO) recommendations	On 10 December 2019, the ICO responded with the following: "We have considered the information you have provided and we have decided that no further action by the ICO is necessary on this occasion. This decision is based on the information we have recorded about the breach. The reasons for our decision are as follows: • This incident affected one person; • This appears to be an isolated incident, there is no evidence of a systemic issue within your organisation; • The staff member was already undergoing disciplinary action and had been referred to the NMC when this separate incident was identified. The original investigations scope has now been extended to cover this incident as well; • At this time, we consider that there is insufficient evidence to substantiate a criminal offence, however we understand that your investigations/disciplinary proceedings are ongoing. Should further evidence become available following the conclusion of your investigation/disciplinary please forward the outcome quoting the above case reference."

Incidents reported to the Information Commissioner's Office

The Trust reported 1 incident to the Information Commissioner's Office:

Date of incident (month)	February 2020
Nature of incident	Lost or stolen paperwork
Nature of data involved	A doctor's backpack was stolen from their car. The backpack contained 1 x handover sheet which included the information relating to 11 patients.
Number of data subjects potentially affected	11
Notification steps	ICO notified and recommendations completed. Remedial steps taken were that a redacted version of this incident has been used as an example in the Trust's Information Governance training presentation in order to remind staff about the importance of keeping information confidential. In addition, the Trust has a technical solution for handovers called Careflow- there is no need for staff to use paper handovers. Therefore, the Caldicott Guardian will meet with the doctor to discuss. The Trust carries out annual spot checks as part of the DSP Toolkit to ensure all staff are adhering to policies and procedures already implemented.
Information Commissioner's Office (ICO) recommendations	On 24 March 2020, the ICO responded with the following: "We have considered the information you have provided and we have decided that no further action by the ICO is necessary on this occasion. This decision is based on the information we have recorded about the breach. The reasons for our decision are as follows: • This breach appears to have been caused by criminal activity combined with a break in procedures rather than systemic failure. • The police have been informed about the theft, the items have not been recovered at this time. • Although you believe there may be some adverse effect due to the breach, its likely any paperwork would be discarded by the criminals as they would most likely be looking for electronic devices to be sold on, and therefore actual detriment would seem unlikely due to the breach. • You are informing the data subjects, which will allow them to take any necessary steps to secure their information. • No actual detriment has been reported at this time."

Data quality and governance

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 year in order to enable providers to focus on areas directly relevant to the COVID-19 response, NHSE and NHSI postponed the requirement for Trusts to provide a quality account until December 2020. Hence this Annual Report for 2019/20 does not contain a quality report section.

The regular quality report to Trust Board provides assurance on the progress of key quality priorities relating to patient safety, patient experience and clinical effectiveness. Key stakeholders including, commissioners, governors and patient representatives also review and scrutinise our quality account priority progress during the year via interactive assurance and workshop sessions.

A range of other reports and dashboards enable the Trust Board to monitor performance and outcomes. The Balance Scorecard provides high level summary on key targets aligned to the five strategic objectives, quality of care, people, and modern healthcare, digital and collaborate. CHKS[5] healthcare intelligence services also enable clinicians to access key quality and performance data for their speciality.

As Chief Executive I am confident in the quality of services we provide across our services and that for the majority of our quality and performance targets we meet the standards expected by and acceptable to our regulator and commissioners.

5. CHKS Limited, part of Capita PLC

Review of effectiveness

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

The following information highlights some of the key methods that the Trust Board uses to be assured its system of internal control is effective.

The Trust Board ensures the effectiveness of the system of internal control through clear accountability and reporting arrangements.

The Trust Board has reviewed the strategic risks and in addition has received regular reports on incidents, claims, complaint trends and Health and Safety.

The Trust Board has established the Audit and Risk Committee and Quality of Care Committee with specific focus on risk management; the Chairs of these Committees report to the Trust Board at the first available Trust Board meeting after each committee meeting. Urgent matters are escalated by the Committee chair to the Trust Board as deemed appropriate.

The Audit and Risk Committee is a formal sub-committee of the Trust Board and is accountable to the Trust Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The Committee meets at least four times per year. The Audit Committee approves the Annual Audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management. The Annual Internal Audit Plan enables the Trust Board to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. During the year, the Committee has reviewed internal and external audit reports, Local Counter Fraud Specialist reports and policies and reviewed progress on meeting the requirements of the Assurance Framework.

The Quality of Care Committee (QCC) has a duty to ensure that the Trust's governance systems, behaviours and processes relating to risk management, clinical and non-clinical governance, and the achievement of organisational objectives are effective, and provide the Trust Board with the assurance required to govern effectively. The Committee met six times in the year and has been reviewing key areas of quality risk to ensure the Trust Board can have sufficient assurance. The Committee is supported by a range of groups including the Quality Governance Committee, Risk Scrutiny Scrutiny Committee and Patient Experience Monitoring Group.

The Modern Healthcare Committee's remit is to review the financial and operational performance, position, risks and decision-making of the Trust. It gives assurance to the Board that this process of review is satisfactory and draws matters of importance to their attention.

The People Committee's role is provide assurance to the Board on workforce supply and demand ensuring staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. The Committee ensures compliance with 'Developing Workforce Safeguards' recommendations and in addition, oversees the development and delivery of the Trust's short, medium and long-term workforce, organisational development, education and training and employee wellbeing strategies. The Committee undertakes a detailed review of the workforce related risks and challenges the workforce and organisational development aspects of the Board Assurance Framework.

Executive Directors have clear responsibilities for internal control and risk management within their area of control. They also have corporate responsibility as Trust Board members.

Internal Audit: BDO LLP are the Trust's providers of internal audit services since June 2017. The contract specifies that the delivery of the internal audit function will continue to be in compliance with the NHS Internal Audit Standards and those of the Institute of Internal Auditors (UK).

The annual opinion given by the Head of Internal Audit for 2019/20 provided moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

External agencies: High level overview of external agency assessments and the associated action plans is overseen by the Quality of Care Committee.

NHS Improvement's (NHSI) NHS Oversight Framework: is a framework designed to help NHS providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding.' Under this framework NHSI segment trusts according to the level of support each trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. The Trust has a segmentation rating of '2' which means NHSI will offer targeted support where there are concerns in relation to one or more of the themes.

A&E: The Trust has struggled with the four hour waiting target throughout the year and has continued to focus much effort on improving the emergency care pathway. However, the Trust did not meet the A&E four hour waiting target for the year, recording a total of 86.1% (NHSI) for the full year and 85.8%, 88.0%, 85.9% and 84.6% respectively for the four quarters of the year.

Performance remained challenging during the year as patient flow across the system was impacted due to; (a) higher than average surges of admissions, (b) reduced staff availability due to vacancies, (c) shortage of community support, and (d) slow flow to the wards creating delays in A&E. The Trust also cared for a greater number of higher acuity patients where patients required a longer length of stay in hospital before their safe discharge. An overarching recovery programme was instituted during the year with the support of a specialist partner. Although A&E performance for the year dropped marginally compared to the previous year, the Trust's position when compared to providers both regionally and nationally improved substantially, confirming the resilience the recovery programme achieved.

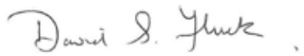
RTT: The Trust started the year with an improving although non-compliant RTT position of 91.5% (Mar 19) and continued to improve the RTT position, remaining compliant through April to December (9 months), until winter pressures and the requirement to defer non-urgent elective surgery caused the Trust to become marginally non-compliant during January and February. However, with the impact of COVID-19 and associated infection control restrictions (including patient choice) during March, the Trust's RTT position fell to 88.2%.

This level of performance during the past year contrasts well with the England national average non-compliant performance recorded through the year.

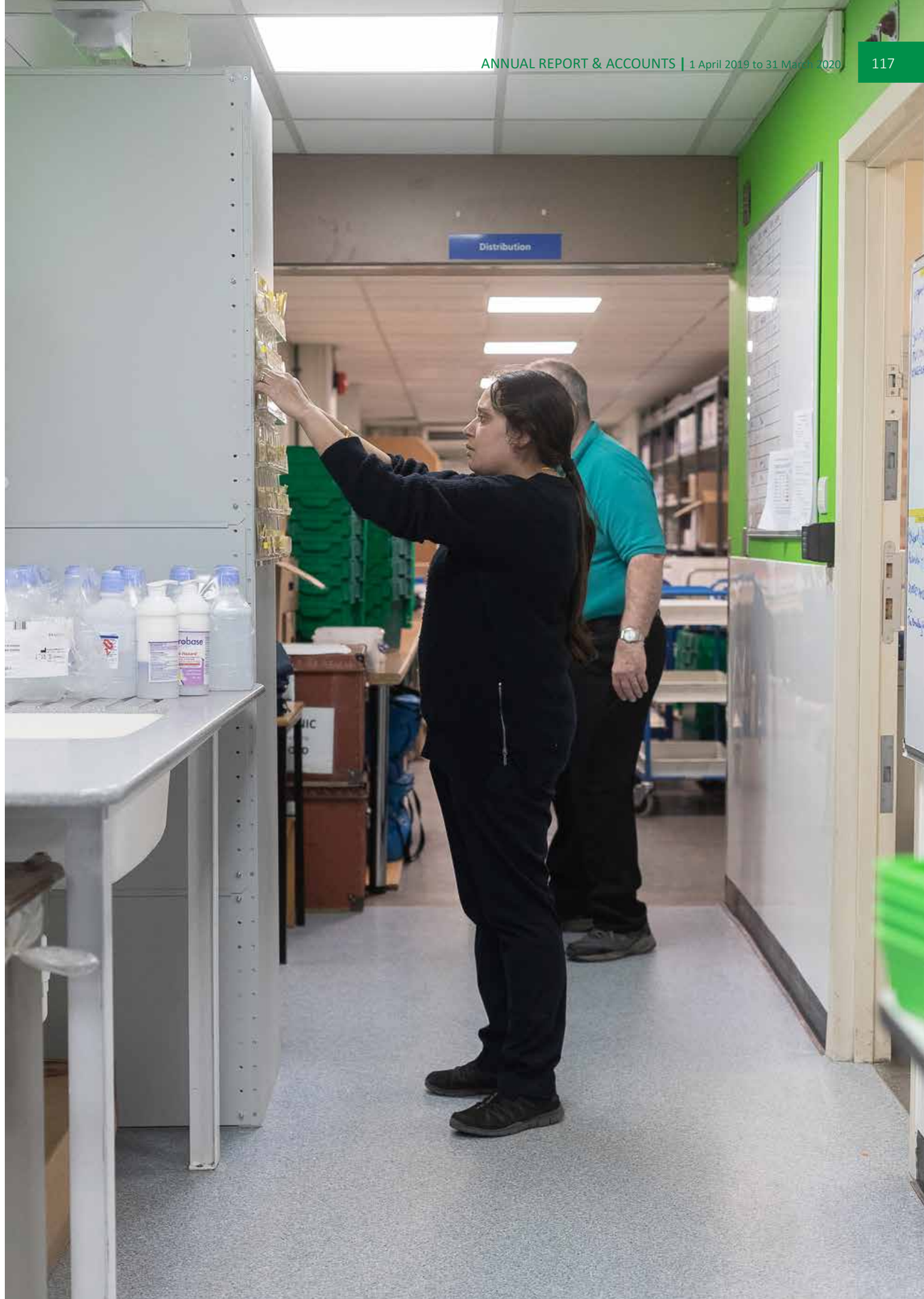
Cancer: The Trust received 18,500 urgent cancer referrals during the year, an overall 9.2% increase compared to the previous year, (35% over 3 years), and has worked with commissioners to address these increases and support delivery of compliant performance. The Trust achieved annual compliance for cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen, although marginally missed annual compliance for treatment within 62 days. However, the Trust's performance compares extremely well against the England national average performance for treatment within 62 days.

Conclusion

I am reporting three significant control issues within the Foundation Trust, being failure to meet the four hour waiting time target, 62 day cancer waiting time targets and non-compliance with RTT targets in 2019/20.



Dr David Fluck
Acting Chief Executive



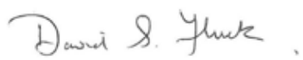
4. ANNUAL ACCOUNTS

5. Annual Accounts

1 April 2019 – 31 March 2020

Foreword to the Accounts

These Accounts for the year ended 31 March 2020 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4)(a) of the National Health Service Act 2006.



Dr David Fluck
Acting Accounting Officer
Ashford and St. Peter's Hospitals NHS Foundation Trust
29 June 2020

Independent Auditor's Report to the Council of Governors of Ashford and St. Peter's Hospitals NHS Foundation Trust

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of Ashford and St Peters NHS Foundation Trust ('the Trust') for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on the overall audit strategy, the allocation of resources in the audit, and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue recognition *The Trust recognised £343 million of revenue from activities in the Statement of Comprehensive Income. The Trust's primary source of revenue is through contracts with commissioning bodies in respect of the provision of acute and community healthcare services. Notes 3.1, 3.2 and 4 provide further information on the nature and source of the Trust's revenue.* ISA (UK) 240 incudes a rebuttable presumption that there is a risk of fraud in relation to revenue recognition. We have not rebutted the presumed risk on the basis that the Trust is under increasing financial pressure in 2019/20 and there is a perceived incentive to recognise revenue before it has been earned. Furthermore, the Trust recognised additional revenue from the Department of Health and Social Care, to fund the Trust's expenditure incurred to respond to the COVID-19 pandemic. We consider there to be a risk of fraudulent revenue recognition in relation to this funding because of the incentive and opportunity to claim for the reimbursement of expenditure that is not COVID-19-related.	Our audit procedures included, but were not limited to: • Evaluating the Trust's accounting policy in respect of revenue recognition to ensure that it is in line with the requirements of the GAM. • Reconciling a sample of revenue recognised through contracts with commissioners, to the underlying contractual agreement and any agreed variations in the year to appropriate evidence. • Testing a sample of other revenue by agreeing the transactions to appropriate source documentation and obtaining assurance that each item was recorded in the correct financial year and at the correct value. • Considering information provided by the Department of Health and Social Care in respect of year-end intra-NHS transactions. We identified any significant differences between the Trust's position and that of the counterparty and obtained assurance that the Trust's position was supported by appropriate evidence. • Testing a sample of expenditure items for which the Trust has recognised additional funding from the Department of Health and Social Care to obtain assurance that these were correctly recorded as COVID-19-related expenditure items that were due to be re-imbursed. **Key observations** We obtained sufficient appropriate evidence to conclude that income recognised in the financial statements is reasonable.
Expenditure recognition *The Trust recognised £336 million of operating expenses in the Statement of Comprehensive Income. The Trust breaks down its expenses incurred in Note 6 of the statements. The Trust's largest expense is Staff Costs, with a charge of £215 million.* For public sector organisations, the same risk applies to the recognition of non-payroll expenditure and contractual obligations. The pressure to manage expenditure, especially when dealing with high cost specialisms that are not specifically funded, increases the risk surrounding fraudulent financial reporting of expenditure. The pressure to manage expenditure to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting of expenditure leading to material misstatement. We have therefore assessed the recognition of expenditure as a significant risk and key audit matter.	Our audit procedures included, but were not limited to: • Reviewing and testing payroll expenditure incurred in the year to ensure payments are made and accounted for correctly. • Testing a sample of non-payroll expenditure items in year to ensure they are correctly accounted for. • Testing of non-payroll expenditure around the year end to ensure transactions are recognised in the correct period. • Testing year end payables, accruals and provisions. • Considering information provided by the Department of Health and Social Care in respect of year-end intra-NHS transactions. We identified any significant differences between the Trust's position and that of the counterparty and obtained assurance that the Trust's position was supported by appropriate evidence. • Testing a sample of expenditure items for which the Trust has recognised additional funding from the Department of Health and Social Care to obtain assurance that these were correctly recorded as COVID-19-related expenditure items. **Key observations** We obtained sufficient appropriate evidence to conclude that expenditure recognised in the financial statements is reasonable.
Valuation of property, plant and equipment *Note 15 to the financial statements discloses information on the Trust's holding of property, plant and equipment (PPE) which includes £160 million of land and buildings held at current value at 31 March 2020. These assets are subject to periodic revaluation in line with the requirements of the Group Accounting Manual (GAM). Note 1.6 to the financial statements describes the Trust's accounting policy with respect to the valuation of land and buildings and note 12 discloses further information on the balance, which includes disclosure of a material valuation uncertainty as a result of the COVID-19 pandemic.* The Trust's holding of PPE includes a portfolio of land and building assets that are held at current value. Management engage a valuation expert ('the valuer') to provide the Trust with valuations in accordance with Royal Institution of Chartered Surveyors (RICS) requirements. We consider there to be a significant risk of material misstatement in relation to the valuation of the Trust's land and buildings as a result of the: • High degree of estimation uncertainty associated with the valuations; • Level of judgement applied by management and the valuer in estimating current values; and • Extent to which the valuations are reliant on complete and accurate source data on individual assets being provided to the valuer. The significant risk of material misstatement is further increased due to the additional estimation uncertainty arising from the COVID-19 pandemic.	Our audit procedures included, but were not limited to: • Obtaining an understanding of the skills, experience and qualifications of the valuer, and considering the appropriateness of the instructions to the valuer from the Trust. • Obtaining an updated understanding of the basis of valuation applied by the valuer in the year. This included understanding and challenging the methodology applied to estimate the gross replacement cost of the Trust's operational land and buildings on a modern equivalent asset basis. • Considering the completeness of the property portfolio covered by the valuer's work. • Reviewing a sample of capital programme additions within the year to ensure these have been appropriately valued • Testing the accuracy of how valuation movements were presented and disclosed in the financial statements. • Making direct enquiries with the valuer and using relevant cost and market data to assess the reasonableness of the valuation as at 31 March 2020. We used this to assess the effect of the material valuation uncertainty disclosed in the valuation report and in the Trust's financial statements. **Key observations** We obtained sufficient appropriate evidence to conclude that the valuation of PPE included in the financial statements is reasonable.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as follows:

	Trust
Overall materiality	£5.00m
Basis for determining materiality	Approximately 1.5% of gross operating expenses
Rationale for benchmark applied	Gross operating expenses is a key measure of financial performance for the users of the financial statements.
Performance materiality	£3.00m
Reporting threshold	£0.15m

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which they operate. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes, controls and their environments, and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items. There were no changes to the scope of the current year audit from the scope in the prior year.

Our tests included, but were not limited to:

- obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by irregularities including fraud or error;
- review of minutes of board meetings in the year;
- discussions with the Trust's internal auditor; and
- enquiries of management.

As a result of our procedures, we did not identify any key audit matters relating to irregularities, including fraud (other than the key audit matter on revenue recognition outlined above). The risks of material misstatement, including due to fraud, that had the greatest effect on our audit, including the allocation of resources and effort, are discussed under 'Key audit matters' within this report.

Other information

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

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

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2019/20; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2019/20; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.

Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a Director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or • we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

This report is made solely to the Council of Governors of Ashford and St Peter's NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of the financial statements of Ashford and St Peters NHS Foundation Trust and Ashford and St Peters NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Lucy Nutley
For and on behalf of Mazars LLP

Mazars LLP
Tower Bridge House,
St Katharine's Way,
London,
E1W 1DD

29 June 2020

Statement of Comprehensive Income for the year ended 31 March 2020

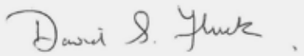
	Note	2019/20 £'000	2018/19 £'000
Income			
Income from patient care activities	3	312,242	282,604
Other operating income	4	31,200	52,972
Operating expenses	6	(336,139)	(300,638)
Operating surplus		**7,303**	**34,938**
Finance costs			
Finance income	12	358	193
Finance expense	13	(339)	(261)
Public dividend capital dividends payable		(6,135)	(6,018)
Other gains/(losses)	14		17,987
Retained surplus/(deficit) for the year		**1,187**	**46,839**
Other Comprehensive Income:			
Impairments – net reversal on property, plant and equipment		(12,278)	(4,462)
Revaluations		147	16,734
Total comprehensive income/(expense) for the year		**(10,944)**	**59,111**

The notes on pages 132 to 173 form part of these accounts.

Statement of Financial Position as at 31 March 2020

	Note	31/03/20 £'000	31/03/19 £'000
Non-current assets			
Property, plant and equipment	15	185,471	179,391
Intangible assets	16	5,462	5,712
Other investments	19	60	60
Receivables	21	7,320	13,716
Total non-current assets		**198,313**	**198,879**
Current assets			
Inventories	20	3,773	3,549
Receivables	21	34,448	50,593
Cash and cash equivalents	22	53,470	43,871
Total current assets		**91,691**	**98,013**
Total assets		**290,004**	**296,892**
Current liabilities			
Trade and other payables	23	(35,898)	(34,604)
Other liabilities	23	(293)	(311)
Borrowings	24	(1,828)	(1,701)
Provisions	26	(1,526)	(1,978)
Total current liabilities		**(39,545)**	**(38,594)**
Total assets less current liabilities		**250,459**	**258,298**
Non-current liabilities			
Borrowings	24	(4,885)	(6,133)
Provisions	26	(336)	(139)
Total assets employed		**245,238**	**252,026**
Financed by taxpayers' equity			
Public dividend capital		93,131	88,975
Income and expenditure reserve		86,907	85,720
Revaluation reserve		65,200	77,331
Total taxpayers' equity		**245,238**	**252,026**

The financial statements on pages 128 to 173 were approved by the Board on 29 June 2020 and signed on its behalf by:



Dr David Fluck,
Acting Accounting Officer

29 June 2020

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

	Public Dividend Capital (PDC) £'000	Retained Earnings £'000	Revaluation Reserve £'000	Total £'000
Changes in taxpayers equity for the year ended 31 March 2020				
Balance at 1 April 2019	88,975	85,720	77,331	252,026
Retained surplus/(deficit) for the year	-	1,187	-	1,187
Public Dividend Capital received	4,156	-	-	4,156
Net impairments	-		(12,278)	(12,278)
Net gain in revaluation of property, plant and equipment	-	-	147	147
Balance at 31 March 2020	**93,131**	**86,907**	**65,200**	**245,238**
Changes in taxpayers equity for the year ended 31 March 2019				
Balance at 1 April 2018	88,889	32,081	71,859	192,829
Retained surplus/(deficit) for the year	-	46,839	-	46,839
Public Dividend Capital received	86	-	-	86
Net impairments	-		(4,462)	(4,462)
Net gain in revaluation of property, plant and equipment	-	-	16,734	16,734
Transfer to retained earnings on disposal of property, plant and equipment	-	6,800	(6,800)	-
Balance at 31 March 2019	**88,975**	**85,720**	**77,331**	**252,026**

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019/20 £'000	2018/19 £'000
Cash flows from operating activities			
Operating surplus		7,303	34,938
Depreciation and amortisation		8,819	7,229
Impairments – net reversal		507	(1,414)
(Increase)/decrease in inventories		(224)	129
(Increase)/decrease in receivables		22,746	(22,853)
Increase/(decrease) in trade and other payables		(4,574)	6,210
Increase/(decrease) in other current liabilities		(18)	188
Increase/(decrease) in provisions	26	(255)	1,553
Other movements in operating cash flows		(309)	(294)
Net cash inflow/(outflow) from operating activities		**33,995**	**25,686**
Cash flows from investing activities			
Interest received		369	179
Purchase of property, plant and equipment and intangible assets		(20,582)	(7,974)
Proceeds from sales of property, plant and equipment		-	8,306
Net cash inflow/(outflow) from investing activities		**(20,213)**	**511**
Net cash inflow/(outflow) before financing		**13,782**	**26,197**
Cash flows from financing activities			
Public Dividend Capital received		4,156	86
Capital element of finance lease rental payments		(1,705)	(1,138)
Interest element of finance lease		(339)	(261)
Interest paid		-	-
Dividends paid		(6,295)	(6,128)
Net cash inflow/(outflow) from financing activities		**(4,183)**	**(7,441)**
Net increase/(decrease) in cash and cash equivalents		**9,599**	**18,756**
Cash (and) cash equivalents at the beginning of the year		**43,871**	**25,115**
Cash (and) cash equivalents at 31 March	**22**	**53,470**	**43,871**

Notes to the Accounts 31 March 2020

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 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.

1.3 Going concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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.

Critical judgements in applying accounting policies

There were no areas of critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have a significant effect on the amounts recognised in the financial statements.

Key sources of estimation uncertainty

Income from patient care activities: where agreement has not already been reached on final contract outturns, invoicing deadlines for NHS income prevent actual activity data from being used for all work performed in March. Income for March is estimated using year to date activity trend data and adjusting this value for the number of working days in March and other known factors.

Incomplete inpatient episodes as at 31 March: where a patient occupies a bed at the financial year end an estimated value for the partially completed spell is calculated using a bed day rate multiplied by the number of days that bed has been occupied. The total value calculated for 2019/20 was £2,438,000 (2018/19: £2,468,000).

Untaken annual leave: Employee Benefits includes an estimate for the value of annual leave earned but not taken at the end of each financial year, and is calculated using an average of 1.00 days per employee. Previously the Trust has used an historic average calculated from enquiries made of business managers which returned a 50% response rate. The number of days has been increased in 2019/20 to reflect the fact that a number of staff cancelled planned leave to help the Trust in its COVID-19 preparations.

In 2019/20 this equated to £668,000 (2018/19: £464,000) and the year on year increase/decrease is accounted for as a salary cost/benefit and reported within note 8.

Provisions: values for provisions are based upon data received from NHS Pensions Agency, NHS Resolution, expert opinion from within the Trust and external professional advisors regarding when

Land and buildings: A valuation exercise was carried out in February and March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19 with market activity being impacted in many sectors. As at the valuation date, the valuer considered that they could attach less weight to previous market evidence and published build cost information for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that they are faced with an unprecedented set of circumstances on which to base a judgement. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

A 1% change in the valuation as at the 31 March 2020 valuation date would have a £1,596,000 impact on the statement of financial position. This would result in a £28,000 impact on the PDC dividend due to be paid next year and accrued in these financial statements.

There are no other key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

1.5 Revenue

1.5.1 Revenue

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

The Trust's income predominantly derives from the delivery of healthcare activity entitlement to payment arising on discharge of the patient, for spells, or attendance at hospital for A&E and outpatients. Main contracts are paid evenly throughout the year with variation invoices raised for under or over-performance. Non-contract activity is invoiced upon delivery of the activity.

Revenue from NHS contracts

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

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

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its main commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;
- The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date;
- The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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.

1.5.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5.3 Other income

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

1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of leave 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

Past and present employees are covered by the provisions of the NHS Pensions 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 Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

The National Employment Savings Scheme (NEST) is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. Contributions to this scheme started in 2013/14 for applicable employees who are not members of the NHS Pensions Schemes.

1.7 Expenditure on other goods and services

Expenditure on other 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.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
  - 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
  - Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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 other than land and buildings are measured subsequently at valuation.

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

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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.

The Trust charges depreciation on revalued assets based on their revalued amount and not their cost. IAS 16 is not prescriptive on the accounting policy to be adopted by reporting entities in respect of this adjustment, and as the Trust does not have complete records of the historical cost of its assets, it now transfers such balances only on ultimate disposal.

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.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights.

They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at valuation by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. 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 their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, 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.

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. 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.

1.11 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.

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the Revaluation Reserve is transferred to Retained Earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the Donated Asset is then transferred to Retained Earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.15 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.

1.16 Climate Change Levy

Expenditure is recognised in line with the levy charged, based on the chargeable rates for energy consumption per the rates detailed in the Climate Change Levy documentation.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

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 for the financial year, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of negative 0.50% (2017/18 positive 0.29%) in real terms. These rates are as follows:

- A nominal short-term rate of 0.51% (2018/19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from the Statement of Financial Position date;
- A nominal medium-term rate of 0.55% (2018/19: 1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date;
- A nominal long-term rate of 1.99% (2018/19: 1.99%) for inflation adjusted expected cash flows over 10 years up to and including 40 years from the Statement of Financial Position date; and
- A nominal very long-term rate of 1.99% (2018/19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 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. The contribution is charged to expenditure. 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 26.

1.19 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 as and when they become due.

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets and financial liabilities

1.21.1 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.

1.21.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases (note 1.13).

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

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

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

The Trust assesses each class of financial asset to determine the historic rate of credit loss applying to that class. That rate is then applied to the value of the financial asset held.

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. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.21.3 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.

1.22 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.

1.23 Foreign exchange

The functional and presentational currencies of the Trust are 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 (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- 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.

1.24 Corporation Tax

The Trust has reviewed its operating activities and determined that as other trading activities are ancillary to the Trust's core activities then the Trust has no liability for corporation tax.

1.25 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. Details of third party assets are given in Note 31 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

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 Trust and represents the Department of Health's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, 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.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health 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, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loan 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 (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.

1.27 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 Trusts not been bearing its 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.

1.28 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity.

The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK Financial Reporting Standard (FRS) 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

The Trust is the Corporate Trustee of the linked NHS Charity, The Ashford and St. Peter's Hospitals Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK FRS 102. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are disclosed as related party transactions in note 30.

1.29 Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.30 Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement.

The Trust runs Berkshire & Surrey Pathology Services along with Frimley Health NHS Foundation Trust, Royal Surrey County Hospital NHS Foundation Trust and Royal Berkshire NHS Foundation Trust. This meets the definition of a joint operation under IFRS 11. Under the contractual arrangement pathology services at the four Trusts are provided jointly.

The Trust accounts for its share of the assets, liabilities, income and expenditure arising from the activities of Berkshire & Surrey Pathology Services, identified in accordance with the Pathology Services Collaboration agreement. Accordingly Frimley Health NHS Foundation Trust, Royal Surrey County Hospital NHS Foundation Trust and Royal Berkshire NHS Foundation Trust also account for their share of the assets, liabilities, income and expenditure in their financial statements.

1.31 Accounting standards, amendments and interpretations in issue but not yet effective or adopted

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

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

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

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

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

Other standards, amendments and interpretations

The DHSC GAM does not require the following IFRS Standard to be applied in 2019/20:

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating Segments

The Trust Board receives financial information for the Trust as a whole, making decisions based on this. The Trust Executive Committee meets once a month and consists of the Trust Executive Directors and Divisional Directors for the Trust's four Clinical Divisions. Segmental analysis is provided below for the total of these Clinical Divisions and Other, which includes the Corporate areas. The key data for these operating segments is:-

	2019/20			2018/19		
	Clinical Divisions £'000	Other £'000	Total Clinical £'000	Divisions £'000	Other £'000	Total £'000
Income	311,844	31,598	343,442	292,014	43,562	335,576
Expenditure	(265,579)	(76,676)	(342,255)	(246,522)	(42,215)	(288,737)
Contribution	**46,265**	**(45,078)**	**1,187**	**45,492**	**1,347**	**46,839**

3. Income from patient care activities

3.1 Income from activities

	2019/20 £'000	2018/19 £'000
Analysis by activity		
Elective income	52,625	52,629
Non-elective income	76,508	66,095
Outpatient income	62,027	57,631
A & E income	18,828	16,409
High cost drugs income	16,781	13,267
Other NHS clinical income	73,382	70,338
Additional pension contribution central funding	7,979	-
COVID-19 income	795	-
Private Patient income	1,905	2,097
Agenda for Change pay award central funding	-	2,613
Other non-protected clinical income	1,412	1,525
Total	**312,242**	**282,604**

In 2018/19 the Department of Health centrally funded the cost of the Agenda for Change pay award that exceeded the 1% that had been included within national tariffs for that year. From 2019/20 this funding is incorporated into tariff for individual services.

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

In 2019/20 the Trust received £795,000 of income to help fund the additional revenue costs the Trust incurred as a result of the COVID-19 pandemic.

		2019/20 £'000	2018/19 £'000
Activity by source			
Clinical Commissioning Groups and NHS England		308,925	276,369
Department of Health and Social Care		20	2,613
Local Authorities		133	142
Non-NHS	- Private patients	1,905	2,097
	- Overseas patients (non-reciprocal)	556	343
	- Injury cost recovery	581	890
	- Other	122	150
Total		**312,242**	**282,604**

Injury cost recovery income is subject to a provision for impairment of receivables of 21.79% (2018/19 – 21.89%) to reflect expected rates of collection.

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. Income from Commissioner Requested Services in 2019/20 was £295,695,000 (2018/19- £274,643,000).

3.2 Income from overseas patients

	2019/20 £'000	2018/19 £'000
Income recognised this year	556	343
Cash payments received in year	224	283
Amounts added to the provision for impairment of receivables	-	66
Amounts written off in year	151	6

4. Other operating income

	2019/20 £'000	2018/19 £'000
Other operating income from contracts with customers		
Research and development	1,233	1,294
Education and training	9,963	9,192
Non-patient care services to other bodies	1,485	1,150
Provider sustainability fund income – 2018/19	495	32,800
Provider sustainability fund income – 2019/20	4,603	
Marginal rate emergency tariff funding	2,781	-
Other income:		
Car parking	2,323	2,433
Estates recharges	348	445
Pharmacy sales	1,295	1,313
Nursery	1,044	936
Other	5,028	2,952
Other non-contract operating income		
Charitable and other contributions to expenditure	309	294
Education and training – notional income from apprenticeship fund	293	163
Total	**31,200**	**52,972**

The Provider Sustainability Fund was introduced in 2016/17 and in 2019/20 the Trust receives funding dependent upon the achievement of quarterly financial targets. In 2018/19 the Trust received a higher allocation from the Provider Sustainability Fund as a result of the higher surplus delivered in that year.

Fees and charges- HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed. This includes car parking and nursery charges:

	2019/20 £'000	2018/19 £'000
Income	3,365	3,468
Full Cost	(3,336)	(3,360)
Surplus/(deficit)	**29**	**108**

5. Additional information on revenue from contracts with customers recognised in the period

	2019/20 £'000	2018/19 £'000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	198	123
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

6. Operating expenses

	2019/20 £'000	2018/19 £'000
Purchase of healthcare from NHS and DHSC bodies	5,311	5,798
Purchase of healthcare from non-NHS and non-DHSC bodies	16,483	13,772
Employee benefits – Non-Executive Directors	146	150
Employee benefits - staff and Executive Directors	214,932	191,148
Gross redundancy payments	341	-
Drugs costs	20,980	21,758
Supplies and services – clinical (excluding drugs)	31,245	29,888
Supplies and services – general	4,211	3,642
Establishment	3,889	2,802
Transport	827	728
Premises	12,241	11,262
Increase/(decrease) in provision for impairment of receivables	(744)	(8)
Depreciation and amortisation	8,819	7,229
Impairments of property, plant and equipment net of (reversals)	507	(1,414)
Auditors remuneration	77	90
Internal audit	55	55
NHS clinical negligence scheme	11,835	9,560
Legal fees	222	263
Consultancy costs	1,139	797
Training, courses and conferences	1,118	814
Rentals under operating leases	655	476
Insurance	301	316
Losses, ex gratia and special payments	136	38
Other	1,413	1,474
Total	**336,139**	**300,638**

This note includes irrecoverable VAT.

Auditors' remuneration

	2019/20 £'000	2018/19 £'000
Audit services – statutory audit	56	56
Audit services – audit related regulatory reporting	2	12
	58	**68**

This note excludes irrecoverable VAT and the fee to audit the Ashford and St. Peter's Hospitals Charitable Fund, both of which are included within the operating expenses charge.

As a result of the COVID-19 pandemic, there has been a change in requirements by NHS Improvement for the Quality Report work in 2019/20. A full review is no longer required for 2019/20 which has led to a reduction in the fee charged by Mazars.

Audit Liability Cap

An engagement letter dated 23 September 2019 was signed with Mazars. Currently the liability of Mazars, its members, partners and staff (whether in contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit is unlimited.

7. Operating leases

As lessee:

	2019/20 £'000	2018/19 £ '000
Payments recognised as an expense:		
Minimum lease payments	655	476
Total	**655**	**476**

	31/03/20 £'000	31/03/19 £'000
Total future minimum lease payments:		
Not later than one year	606	536
Between one and five years	1,393	1,411
Later than five years	-	-
Total	**1,999**	**1,947**

8. Employee benefits

	2019/20 £'000	2018/19 £'000
Salaries and wages	162,169	149,619
Social security costs	16,346	14,814
Employer's contribution to NHS pensions	18,349	16,754
Pension cost - employer contributions paid by NHS England on the Trust's behalf (6.3%)	7,979	-
Apprenticeship levy	797	727
Pension cost – other	26	14
Temporary staff (including agency)	16,263	13,634
Total gross staff costs	**221,929**	**195,562**
Recoveries in respect of seconded staff	(6,997)	(3,745)
Total staff costs	**214,932**	**191,817**
Of which		
Costs capitalised as part of assets	**913**	**669**

The Apprenticeship Levy was introduced by the UK Government on 6 April 2017, requiring all employers operating in the UK, with a pay bill over £3 million each year, to invest in apprenticeships. The amount of the levy is 0.5% of the applicable pay bill, less an allowance of £15,000.

9. Pension costs

9.1 NHS Pension Scheme

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 for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

9.2 National Employment Savings Scheme (NEST)

Employees who are not members of the NHS Pensions Scheme may join the National Employment Savings Scheme which is a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

10. Retirements due to ill-health

During the year ended 31 March 2020 there were three early retirements (2018/19- none) from the Trust agreed on the grounds of ill-health with a value of £149,000 (2018/19- £nil).

11. Better Payment Practice Code

Better Payment Practice Code - measure of compliance

	2019/20		2018/19	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the year	93,755	131,027	88,699	105,386
Total Non-NHS trade invoices paid within target	87,447	118,209	80,335	91,467
Percentage of Non-NHS trade invoices paid within target	**93.27%**	**90.22%**	**90.57%**	**86.79%**
Total NHS trade invoices paid in the year	1,817	20,065	1,762	15,452
Total NHS trade invoices paid within target	1,214	15,513	1,095	5,848
Percentage of NHS trade invoices paid within target	**66.81%**	**77.32%**	**62.15%**	**37.85%**

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

12. Finance income

	2019/20 £'000	2018/19 £'000
Interest revenue		
Bank accounts	**358**	**193**

13. Finance expense

	2019/20 £'000	2018/19 £'000
Interest costs		
Interest on obligations under finance leases	**339**	**261**

14. Other gains and losses

	2019/20 £'000	2018/19 £'000
Gains on disposal of property, plant and equipment	-	18,310
Losses on disposal of property, plant and equipment	-	(263)
Losses on disposal of intangible assets	-	-
Fair value gains/(losses) on financial assets / investments	-	(60)
Total	**-**	**17,987**

During 2018/19 the Trust sold three plots of land known as the West Site and Optivo Housing at St. Peter's Hospital and the Estates Yard at Ashford Hospital, generating gains on disposal of £18,310,000. The Trust also demolished some buildings known as The Ramp to create a new car park and access road. This created a loss on disposal of £263,000.

The 2018/19 fair value loss relates to the valuation of the Trust's investment in Beautiful Information Limited (see note 19).

15. Property, plant and equipment

2019/20	Land £'000	Buildings excluding dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport & equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2019	**32,550**	**131,749**	**2,967**	**38,655**	**116**	**14,901**	**5,012**	**225,950**
Additions purchased	-	3,670	18,963	1,941	16	939	54	25,583
Additions leased	-	-	-	583	-	-	-	583
Additions donated	-	114	-	175	-	-	20	309
Reclassifications	-	7,953	(10,760)	2,169	-	478	-	(160)
Impairments charged to operating expenses	-	(531)	-	-	-	-	-	(531)
Impairments charged to the revaluation reserve	(8,080)	(4,468)	-	-	-	-	-	(12,548)
Reversal of impairments credited to operating expenses	-	24	-	-	-	-	-	24
Reversal of impairments credited to revaluation reserve	-	270	-	-	-	-	-	270
Revaluations	-	(3,695)	-	-	-	-	-	(3,695)
Disposals/derecognition	-	-	-	(527)	-	(139)	-	(666)
At 31 March 2020	**24,470**	**135,086**	**11,170**	**42,996**	**132**	**16,179**	**5,086**	**235,119**
Depreciation at 1 April 2019	-	-	-	29,863	61	12,313	4,322	46,559
Charged during the year	-	3,842	-	2,445	10	1,132	168	7,597
Revaluations	-	(3,842)	-	-	-	-	-	(3,842)
Disposals/derecognition	-	-	-	(527)	-	(139)	-	(666)
Depreciation at 31 March 2020	**-**	**-**	**-**	**31,781**	**71**	**13,306**	**4,490**	**49,648**
Net book value at 31 March 2020	**24,470**	**135,086**	**11,170**	**11,215**	**61**	**2,873**	**596**	**185,471**
Net book value								
Purchased	24,470	132,125	11.170	4,975	61	2,873	570	176,244
Finance leased	-	2,025	-	5,682	-	-	-	7,707
Donated	-	936	-	558	-	-	26	1,520
Total at 31 March 2020	**24,470**	**135,086**	**11,170**	**11,215**	**61**	**2,873**	**596**	**185,471**

2018/19	Land £'000	Buildings excluding dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport & equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2018	**30,175**	**133,709**	**1,777**	**36,859**	**116**	**13,608**	**4,691**	**220,935**
Additions purchased	-	1,425	5,065	703	-	726	102	8,021
Additions leased	-	88	2,169	1,062	-	-	-	3,319
Additions donated	-	123	-	171	-	-	-	294
Reclassifications	-	3,115	(6,044)	166	-	567	219	(1,977)
Impairments charged to operating expenses	-	(251)	-	-	-	-	-	(251)
Impairments charged to the revaluation reserve	-	(5,179)	-	-	-	-	-	(5,179)
Reversal of impairments credited to operating expenses	-	1,665	-	-	-	-	-	1,665
Reversal of impairments credited to revaluation reserve	-	717	-	-	-	-	-	717
Revaluations	9,277	(226)	-	-	-	-	-	9,051
Disposals/derecognition	(6,902)	(3,437)	-	(306)	-	-	-	(10,645)
At 31 March 2019	**32,550**	**131,749**	**2,967**	**38,655**	**116**	**14,901**	**5,012**	**225,950**
Depreciation at 1 April 2018	-	5,237	-	27,963	52	11,214	4,152	48,618
Charged during the year	-	2,751	-	2,206	9	1,099	170	6,235
Revaluations		(7,683)	-	-	-	-	-	(7,683)
Disposals/derecognition	-	(305)	-	(306)	-	-	-	(611)
Depreciation at 31 March 2019	**-**	**-**	**-**	**29,863**	**61**	**12,313**	**4,322**	**46,559**
Net book value at 31 March 2019	**32,550**	**131,749**	**2,967**	**8,792**	**55**	**2,588**	**690**	**179,391**
Net book value								
Purchased	32,550	128,635	798	4,223	55	2,588	681	169,530
Finance leased	-	2,263	2,169	4,013	-	-	-	8,445
Donated	-	851	-	556	-	-	9	1,416
Total at 31 March 2019	**32,550**	**131,749**	**2,967**	**8,792**	**55**	**2,588**	**690**	**179,391**

The Trust had its land and buildings revalued as at 31 March 2019 and had a desktop valuation as at 31 March 2020 by Cushman & Wakefield. These resulted in impairments and revaluations for 2018/19 and 2019/20 as set out in the tables above. The effects on income and expenditure and revaluation reserve for those financial years are shown in note 17.

The economic lives of property, plant and equipment are:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	10	53
Plant & Machinery	3	15
Transport Equipment	5	10
Information Technology	3	10
Furniture & Fittings	5	10

16. Intangible fixed assets

2019/20	Software Licences £'000	Total £'000
Gross cost at 1 April 2019	11,597	11,597
Reclassifications	160	160
Additions purchased	812	812
Gross cost at 31 March 2020	**12,569**	**12,569**
Amortisation at 1 April 2019	5,885	5,885
Charged during the year	1,222	1,222
Amortisation at 31 March 2020	**7,107**	**7,107**
Net book value		
- Purchased	5,462	5,462
- Donated	-	-
Total at 31 March 2020	**5,462**	**5,462**

2018/19	Software Licences £'000	Total £'000
Gross cost at 1 April 2018	9,369	9,369
Reclassifications	1,977	1,977
Additions purchased	251	251
Gross cost at 31 March 2019	**11,597**	**11,597**
Amortisation at 1 April 2018	4,891	4,891
Charged during the year	994	994
Amortisation at 31 March 2019	**5,885**	**5,885**
Net book value		
- Purchased	5,712	5,712
- Donated	-	-
Total at 31 March 2019	**5,712**	**5,712**

The Revaluation Reserve balance for intangible assets is £nil (2018/19 - £nil).

The economic lives of intangible assets are:

	Minimum life (years)	Maximum life (years)
Software licences	3	10

17. Impairments

Impairments of property, plant and equipment during the year are summarised below:

	2019/20		2018/19	
	Income and Expenditure £'000	Revaluation Reserve £'000	Income and Expenditure £'000	Revaluation Reserve £'000
Revaluation of Estate				
- Revaluation of land and buildings	-	147	-	16,734
- Impairment of land and buildings	(531)	(12,548)	(251)	(5,179)
- Reversal of prior year impairments of buildings	24	270	1,665	717
Total net	**(507)**	**(12,131)**	**1,414**	**12,272**

18. Capital commitments

Contracted capital commitments were as follows:

	31/03/20 £'000	31/03/19 £'000
Property, plant and equipment	10,145	3,670
Intangibles	-	-
Total	**10,145**	**3,670**

As set out in Note 25, in 2013/14 the Trust entered into a Managed Equipment Service contract for Imaging equipment and £3,196,000 (2018/19- £3,670,000) is included in the above total in respect of this contract.

19. Other investments

	31/03/20 £'000	31/03/19 £'000
Carrying value at 1 April	60	120
Movement in fair value through income and expenditure	-	(60)
Carrying value at 31 March	**60**	**60**

The Trust holds 900 Class C shares in Beautiful Information Limited- these were purchased for £120,000 in October 2016. Following a fair value review of this investment the carrying value was reduced by £nil in 2019/20 (2018/19- £60,000).

20. Inventories

	31/03/20 £'000	31/03/19 £'000
Drugs	1,063	810
Consumables	2,687	2,714
Energy	23	25
Total	**3,773**	**3,549**

21. Trade and other receivables

21.1 Trade and other receivables

	Current		Non-current	
	31/03/20 £'000	31/03/19 £'000	31/03/20 £'000	31/03/19 £'000
Contract receivables	£'000	£'000	£'000	£'000
Capital receivables	17,273	42,452	656	891
Trade receivables	13,428	6,960	6,413	12,825
Allowance for impaired contract receivables/assets	(759)	(1,580)	-	-
Prepayments	1,653	1,528	-	-
VAT	1,723	776	-	-
PDC dividend receivable	262	102	-	-
Other receivables	868	355	-	-
Clinician pension tax provision reimbursement funding from NHS England	-	-	251	-
Total	**34,448**	**50,593**	**7,320**	**13,716**

Capital receivables include £19,775,000 (2018/19: £19,775,000) due from Cala Homes following the sale of the West Site, St. Peter's Hospital in 2018/19. Of this £13,362,000 (2018/19: £6,950,000) is within current capital receivables and £6,413,000 (2018/19: £12,825,000) is shown as non-current capital receivables.

21.2 Allowances for credit losses

	31/03/20		31/03/19	
	Contract receivables & contract assets £'000	All other receivables £'000	Contract receivables & contract assets £'000	All other receivables £'000
Allowances at 1 April – brought forward	**1,580**	**-**	**1,984**	**-**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-	(393)	-
New allowances arising	246	-	403	-
Changes in existing allowances	(95)	-	(12)	-
Reversals of allowances	(895)	-	(399)	-
Utilisation of allowances (write offs)	(77)	-	(3)	-
Allowances at 31 March	**759**	**-**	**1,580**	**-**

22. Cash and cash equivalents

	31/03/20 £'000	31/03/19 £'000
Cash with Government Banking Service	53,451	43,720
Commercial banks and cash in hand	19	151
Balance at 31 March	**53,470**	**43,871**

23. Trade and other payables

	Current		Non-current	
	31/03/20 £'000	31/03/19 £'000	31/03/20 £'000	31/03/19 £'000
Trade payables	9,277	16,255	-	-
Capital payables	8,314	2,446	-	-
Accruals	10,160	7,954	-	-
Other payables	8,147	7,949	-	-
Trade and other payables	**35,898**	**34,604**	**-**	**-**
Deferred income: contract liabilities	293	311	-	-
Other liabilities	**293**	**311**	**-**	**-**

24. Borrowings

	Current		Non-current	
	31/03/20 £'000	31/03/19 £'000	31/03/20 £'000	31/03/19 £'000
Finance lease liabilities	**1,828**	**1,701**	**4,885**	**6,133**

25. Finance lease obligations

Amounts payable under finance leases:	Minimum lease payments	
	31/03/20 £'000	31/03/19 £'000
Within one year	2,116	2,028
Between one and five years	4,559	5,897
Later than five years	875	1,107
Less future finance charges	(837)	(1,198)
Net lease liabilities	**6,713**	**7,834**

In 2013/14 the Trust entered into a ten year Managed Equipment Scheme for Imaging equipment and also entered into a ten year agreement for a Cardiac Catheterisation service. The property, plant and equipment under both of these schemes have been treated as finance lease arrangements.

In 2018/19 the Trust entered into a ten year agreement for the provision of an MRI service. The property, plant and equipment under this agreement has been treated as a finance lease arrangement.

26. Provisions for liabilities and charges

	Pensions – early departure costs £'000	Pensions - injury benefits £'000	Legal claims £'000	Clinician pension tax reinbursement £'000	Other £'000	Total £'000
At 1 April 2019	**148**	**61**	**29**	**-**	**1,879**	**2,117**
Arising during the year	-	-	46	251	152	449
Used during the year	(41)	(22)	(29)	-	(420)	(512)
Reversed unused	-	-	(3)	-	(189)	(192)
At 31 March 2020	**107**	**39**	**43**	**251**	**1,422**	**1,862**
Expected timing of cashflows:						
Not later than one year	38	23	43	-	1,422	1,526
Later than one year and not later than five years	69	16	-	251	-	336
Later than five years	-	-	-	-	-	-
As at 31 March 2020						
Current	38	23	43	-	1,422	1,526
Non-Current	69	16	-	251	-	336
As at 31 March 2019						
Current	48	22	29	-	1,879	1,978
Non-Current	100	39	-	-	-	139

Clinical negligence provisions

Included in the provisions of NHS Resolution at 31 March 2020 is £191,875,000 (2018/19- £189,893,000) in respect of clinical negligence liabilities of the Trust.

Legal claim provisions

The majority of these provisions relate to claims under the Liabilities to Third Parties Scheme and Property Expenses Scheme, and are calculated based on information provided by NHS Resolution. The amounts involved and the timing of the payments represents their best estimate of the outcome of each claim against the Trust. In addition to these provisions, contingent liabilities in respect of the claims are given in note 27.

Clinician pension tax reimbursement

Clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in this tax year (2019/20), face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold, will be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31 July 2021).

The Trust will make a contractually binding commitment to pay them a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement.

The Trust has created a provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This will be offset by the commitment from NHS England and the Government to

fund the payments to clinicians as and when they arise. The provision and offsetting asset will initially increase year on year in line with the pension scheme growth, and be released as commitments are met, i.e. as eligible members retire under the rules of the NHS Pension Scheme.

Other provisions

Other provisions at 31 March 2020 include: -

- £150,000 (2018/19: £224,000) in respect of clinical excellence awards;
- £104,000 (2018/19: £140,000) in respect of employment tribunal claims;
- £128,000 (2018/19: £418,000) in respect of consultants pay appeals; and
- £1,040,000 (2018/19: £1,097,000) in respect of cost provisions associated with two land sales completed in March 2019 – predominantly S106 requirements from the local council.

27. Contingent assets/(liabilities)

Other

Other Contingent Liabilities for non-clinical negligence incidents total £22,000 (2017/18- £24,000).

28. Financial instruments

28.1 Carrying value of financial assets

	31/03/20		
	Held at amortised cost £'000	Held at fair value through I&E £'000	Total book value £'000
Trade and other receivables	38,129	-	38,129
Other investments	-	60	60
Cash and cash equivalents at bank and in hand	53,470	-	53,470
Total at 31 March 2020	**91,599**	**60**	**91,659**

	31/03/19		
	Held at amortised cost £'000	Held at fair value through I&E £'000	Total book value £'000
Trade and other receivables	61,903	-	61,903
Other investments	-	60	60
Cash and cash equivalents at bank and in hand	43,871	-	43,871
Total at 31 March 2019	**105,774**	**60**	**105,834**

28.2 Carrying value of financial liabilities

Carrying values of financial liabilities as at 31 March 2020:

	31/03/20	
	Held at amortised cost £'000	Total book value £'000
Trade and other payables excluding non financial liabilities	30,865	30,865
Obligations under finance leases	6,713	6,713
Total at 31 March 2020	**37,578**	**37,578**

	31/03/19	
	Held at amortised cost £'000	Total book value £'000
Trade and other payables excluding non financial liabilities	30,241	30,241
Obligations under finance leases	7,834	7,834
Total at 31 March 2019	**38,075**	**38,075**

28.3 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is considered to be a reasonable approximation of fair value.

28.4 Maturity of financial liabilities

	31/03/20 £'000	31/03/19 £'000
In one year or less	32,693	31,942
In more than one year but not more than two years	1,890	1,821
In more than two years but not more than five years	2,128	3,444
In more than five years	867	868
Total at 31 March	**37,578**	**38,075**

28.5 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 the Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities 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. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

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

Interest Rate Risk

The Trust can borrow from Government for capital expenditure, subject to affordability. 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. Interest charged on finance leased assets are at fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

Because of the majority of the Trust's income 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. The Trust recognises that the public sector funding environment, with the continued pressure of demand and its consequences for allocations for Clinical Commissioning Groups, leads to an increase in credit risk for the Trust.

Liquidity risk

The Trust's operating costs are incurred under contract with Clinical Commissioning Groups which are financed from resources voted annually by Parliament. The Trust funds it capital expenditure from internally generated funds and finance leases/borrowings. The Trust is not, therefore, exposed to significant liquidity risks.

29. Events after the reporting period

There were no events after the reporting period requiring disclosure.

30. Related party transactions

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Ashford and St Peter's Hospitals NHS Foundation Trust. However, Non-Executive Director Hilary McCallion had declared her role as a Trustee for Dementia UK to which the Trust paid £2,000 in 2019/20 (2018/19: £4,000). In addition, Non-Executive Director Marcine Waterman has declared her role as Central Government Faculty Board Member at CIPFA to which the Trust paid £246 in 2019/20 (2018/19: £240).

As set out in note 19 the Trust purchased shares in Beautiful Information Limited in October 2016. As a result of this investment the Trust is able to appoint one Director to the Board of Beautiful Information Limited which is currently the Trust's Director of Finance and Information. There is no remuneration or other form of personal benefit for this role. During 2019/20 the Trust procured £60,000 of services from Beautiful Information Limited (2018/19: £28,000).

The Department of Health and Social Care is the Trust's parent department and is therefore regarded as a related party. During the period Ashford and St Peter's Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department the main ones being:

- NHS England
- Health Education England
- NHS North West Surrey CCG
- NHS Hounslow CCG
- NHS Surrey Downs CCG
- NHS East Berkshire CCG
- NHS Richmond CCG
- NHS Guildford and Waverley CCG
- NHS Surrey Heath CCG
- NHS North East Hampshire and Farnham CCG
- Frimley Health NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust
- Royal Surrey County NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- NHS Blood and Transplant
- NHS Resolution
- NHS Pensions Scheme
- NHS Property Services
- NHS Business Services Authority
- NHS Supply Chain

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with H M Revenue and Customs, Surrey County Council, Runnymede Borough Council and Spelthorne Borough Council.

The Trust has also received revenue and capital payments from the Ashford and St. Peter's Hospitals Charitable Fund. The Board members of the Trust are also Trustees of this charity. The audited annual report and accounts of the Charity are available to the public on request.

31. Third party assets

The Trust held £9,000 cash at bank and in hand at 31 March 2020 (2018/19- £9,000) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

32. Losses and special payments

Losses and special payments are transactions 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. Payments are made in accordance with the HM Treasury publication "Managing Public Money".

There were 83 cases (2018/19 – 50) of losses and special payments totalling £227,000 paid in 2019/20 (2018/19- £80,000). The write off of 20 overseas debt cases resulted in £151,000 of the losses. There were no cases where the net payment exceeded £100,000. Total costs included in this note are on an accruals basis excluding provisions for future losses.

	31/03/20		31/03/19	
	No. of Cases	Total	No. of Cases	Total
	£'000	£'000	£'000	£'000
Losses of cash	2	3	1	-
Bad debts and claims abandoned	26	152	3	6
Damage to buildings, property etc.	-	-	1	20
Ex gratia payments	55	72	45	54
Total at 31 March 2020	**83**	**227**	**50**	**80**

33. Event after the reporting date

The UK Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2020/21, and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year.

Providers can therefore expect NHS funding to flow at similar levels to that previously provided, where services are reasonably still expected to be commissioned. Whilst mechanisms for contracting and payment are not definitively in place, it is clear that government financial support is available. For the period April 2020 to October 2020, the Trust is receiving income via an interim, nationally set, block contract and top-up mechanism.