NHS

Surrey and Sussex Healthcare

NHS Trust

Annual Report 2020-21

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Performance report

Performance Overview

Purpose

In this report you can find out more about our plans, our performance and our achievements from 2020/21. This was a year like no other, so this report also gives us an opportunity to reflect on our contribution during the COVID-19 pandemic.

Foreword

This year has been a year like no other. The NHS has faced arguably the most challenging period in its history due to the COVID-19 pandemic. Here at Surrey and Sussex Healthcare NHS Trust the virus impacted every area of our work, not to mention the lives of all of our staff and those we serve.

We began 2020/21 in the early stages of the pandemic and in the first peak of the Spring East Surrey Hospital was one of the most affected hospitals in our region. Staff worked rapidly to reorganise our services to enable us to care for people needing treatment for COVID-19 while we learnt more and more about the virus every day.

We managed to more than triple our critical care capacity, converting medical wards into spaces that could provide care for some of our most critically unwell patients. At the same time, staff changed roles and many volunteered to work in unfamiliar areas to make sure patients could get the care they needed.

Like the rest of the NHS, we postponed lots of planned operations and procedures so while our clinical teams were caring for rising numbers of patients needing support, scores of SASH staff set about the enormous task of reorganising appointments and keeping patients informed. Many of our clinical staff, such as those who usually work in operating theatres, were redeployed to support areas such as critical care or our COVID medical wards. Simultaneously, our procurement department led our efforts to ensure we maintained supplies of the new equipment and kit that we needed – particularly personal protective equipment (PPE) – while our estates department made the necessary adaptations to the infrastructure of our buildings. It is important to place on record our gratitude for the speed and professionalism with which our staff made these significant changes that would go on to provide the basis for our response throughout the year. You can read more about the detail of this response in the dedicated section in this report.

Of course throughout the year there were many people who continued to require care for non-COVID issues. Our teams worked tirelessly to continue to provide this care wherever possible. For example, we embraced new ways of working with many more consultations being undertaken virtually, over the phone or via online video services. Our emergency department continued to treat people throughout the pandemic and we expanded our capacity to help us keep people with COVID separate from those in hospital for other reasons.

In this most extraordinary of years we managed to deliver a small financial surplus when fixed asset valuation impairments and donated asset technical adjustment are removed. We were again able to invest in our services, with around £22m of capital funding spent on improvements to our facilities. For example, early in the year we made the finishing touches to our state-of-the-art neonatal unit – an £8.6m investment over recent years. We opened a new purpose-built MRI department at East Surrey Hospital, boasting two state-of-the-art scanners as well as one of the UK's first ceiling mounted MRI injector systems. We also made numerous improvements to help us to respond to the pandemic, such as creating a new unit for same day emergency care and creating more endoscopy capacity.

Our colleagues again ranked SASH among the best NHS trusts in the country in the annual national survey of NHS employees. The Trust's staff rated the organisation fourth best acute trust in the country when asked if they would recommend it as a place to work, while we also scored highest nationally for staff stating they look forward to coming to work. This was particularly pleasing during such a difficult year. It has never been more important to make the NHS the best place to work and that's why staff welfare is a key priority for us in the months ahead.

We made good progress on our inclusion agenda for patients and staff, though events of the past year have highlighted just how much more work there is to do in this area across the country. We were proud to prioritise support for those who have been disproportionately impacted by the pandemic, such as people from black, Asian and minority ethnic backgrounds, and there is much more we want to do. To spearhead that work we appointed a Head of Inclusion, while the Board regularly reviews our progress as part of our board assurance framework.

We also continued to work with health and care partners, collaborating and integrating services to improve the health of the population and the experience patients have when they need care. For example, despite the challenges of the pandemic, we managed to bring over 40 experts from our Trust and Surrey and Borders Partnership NHS Foundation Trust (SABP) together every day for a whole week to plan how services can improve now and in the future. This first joint integrated care improvement and visioning event was a really positive and practical step forward.

As we reached the end of 2020/21, we were proud to play our part in the biggest vaccination programme in NHS history, providing COVID-19 vaccinations for health and care staff at East Surrey Hospital. A dedicated team worked with incredible pace and drive to set up the systems we needed to have in place to vaccinate thousands of people quickly and safely.

This has provided us with hope and optimism as we look ahead to 2021/22. However, this year will always be remembered for those who did not survive COVID-19. All of our thoughts are with our patients, our friends, our relatives and our colleagues who lost their lives.

Richard Shaw, chair

Michael Wilson CBE, chief executive

NHS
Surrey and Sussex Healthcare
NHS Trust

Surrey and Sussex Healthcare NHS Trust:

- East Surrey Hospital
- Crawley Hospital
- Horsham Hospital
- Caterham Dene Hospital
- Serving a population of 535,000
- 5,000 staff

Last year we had:

- 350,647 outpatient appointments
- 34,687 planned admissions
- 4,396 births
- 33,062 emergency admissions
- 91,922 A&E attendances

About us

Surrey and Sussex Healthcare NHS Trust (SASH) provides acute and complex services at East Surrey Hospital in Redhill alongside a range of outpatient, diagnostic and planned care at Caterham Dene Hospital and The Earlswood Centre in Surrey and at Crawley and Horsham Hospitals in West Sussex. Serving a growing population of over 535,000 we care for people living, working and visiting east Surrey, northeast West Sussex, and south Croydon, including the towns of Crawley, Horsham, Reigate and Redhill.

East Surrey Hospital is the designated hospital for Gatwick Airport and sections of the M25 and M23 motorways. It has a trauma unit, which cares for seriously injured patients in partnership with the major trauma centres at St George's University Hospitals NHS Foundation Trust, Tooting, and Royal Sussex County Hospital, Brighton. East Surrey Hospital has 771 beds and ten operating theatres, along with four more theatres at Crawley Hospital in a day surgery unit.

We are a major local employer, with a diverse workforce of around 5,000 staff providing healthcare services to the communities we serve. The Trust is an Associated University Hospital of Brighton and Sussex Medical School and we are part of educating cohorts of final year medical students from the school each year under the supervision of one of our consultants. Our involvement supports the medical workforce of the future and the delivery of high-quality patient care.

Our vision

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

Our values

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

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

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

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

Our Clinical Commissioning Groups

The services we provide are commissioned by local clinical commissioning groups (CCGs) as well as NHS England & NHS Improvement and Sussex Musculoskeletal Partnership Central (MSK).

The Trust holds a contract with local CCGs which covers the majority of clinical services we provide. The Trust also holds a contract with NHS England & NHS Improvement, who commission specialised services and secondary care dental services. Sussex Musculoskeletal Partnership Central is hosted by a limited company in the north of West Sussex, who commission a range of outpatient and inpatient services from the Trust.

Under the CCG contract, the majority of our services are commissioned by:

NHS Surrey Heartlands CCG: Covering around one million people across the following boroughs and districts: Elmbridge, Epsom and Ewell, Guildford, Mole Valley, Reigate and Banstead, Runnymede, Spelthorne, Tandridge, Waverley and Woking. This represents around three quarters of the Surrey population.

NHS West Sussex CCG: Serving a population of over 860,000 people living in the districts of Crawley, Horsham and the surrounding areas including Burgess Hill, East Grinstead, Haywards Heath plus the West Sussex coastal districts of Adur, Arun, Chanctonbury, Chichester, Cissbury and Regis.

Clinically led

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

Cancer and diagnostics:

- Chief - Dr Tony Newman-Sanders
- Associate director - Alison James
- Divisional chief nurse - Paula Tooms

Medicine

- Chief - Dr Ben Mearns
- Associate director - Cynthia Quainoo
- Divisional chief nurse – Hannah Tompsett (Nicola Shopland until May 2020)

Surgery

- Chief - Mr Ian Maheswaran
- Associate director - Natasha Hare
- Divisional chief nurse - Jamie Moore

Women and children

- Chief - Miss Karen Jermy
- Associate director - Riyadh Seebooa
- Divisional chief nurse - Michelle Cudjoe (Director of midwifery)

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

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

Our CQC rating

In January 2019 the CQC rated SASH outstanding overall and commended the organisation for the quality of care and its use of resources.

There were no updates to the below ratings in 2020/21.

Rating for acute services/acute trust

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

COVID-19: our response

- Over 2100 people recovered enough to be discharged having been an inpatient with COVID-19
- Our eldest patient to recover after an inpatient stay with COVID was over 100
- We increased our critical care capacity by 300%
- Over 17,500 appointments took place online in 2020/21, up from just 130 in the previous year
- The chaplaincy and spiritual care team provided bereavement support to over 800 families and hundreds of staff
- Over 260 staff were redeployed to critical care
- Over 99% of SASH staff completed an individual COVID risk assessment
- 9,214 doses of COVID vaccine given at East Surrey Hospital, including 450 in one day

By the start of 2020/21 we were already significantly impacted by the COVID-19 pandemic. Staff across the Trust set about transforming our infrastructure to enable us to provide the care we would need to in the months ahead.

This involved significantly increasing our critical care capacity, converting medical wards so that they were equipped to provide more intensive care. This was no small undertaking, with teams collaborating to make changes at an unprecedented pace.

It also involved many staff changing their roles. Hundreds of members of our One Team volunteered to work in different areas to provide the care our community required. The impact of this should not be underestimated – many left areas they had spent years developing and shaping, and quickly familiarised themselves with new departments and responsibilities. They made enormous sacrifices to ensure patients could access the care they needed. In some cases this even involved moving hospitals – the Crawley day surgery team, for example, moved to East Surrey Hospital during the first peak.

While the number of people with COVID continued to rise, clinical teams designed new pathways to care for them safely. Our infection control team were on hand throughout to guide and advise colleagues across the organisation; this year's Quality Account sets out in more detail how we approached this in line with national guidance. This guidance and advice extended beyond our organisation – early on in the pandemic our experts worked closely with care homes to aid training and understanding among their staff.

Departments across the Trust were affected by the rise in patients. Staff on our wards worked tirelessly to care for unprecedented numbers of patients, many of whom were very unwell with the virus. Our critical care team, along with the hundreds of colleagues supporting them, looked after numbers of patients never seen before. This of course had a profound impact on colleagues across the organisation who were required to provide increased support. People from our estates and facilities teams, our diagnostic services, our administrative and managerial colleagues, people in our bereavement and mortuary services, as well as all of our clinical staff were put under immense pressure. Throughout this period many staff members became seriously unwell too – at times we had around 900 colleagues absent - and our teams showed remarkable courage to continue to provide the care patients needed while they were so concerned for their colleagues, their loved ones and themselves.

While this was ongoing, teams behind the scenes pulled out all the stops to reorganise appointments and procedures to make sure capacity to care for people with COVID was available. As described elsewhere in this report, like the rest of the NHS many routine operations were postponed, yet we continued to provide the most time-critical surgery throughout the year.

We put in place numerous mechanisms to support our new working arrangements, such as a message service for family and friends to keep in touch with loved ones

who they were not able to visit as frequently. While visiting restrictions were necessary, teams across the Trust were proud to continue facilitating visits when people were at the end of their life, or for those patients who required additional support. We may not have always got this right and we acknowledge that the impact this had on some patients and their loved ones.

On a daily basis, the procurement department worked wonders to keep our teams stocked with personal protective equipment and other supplies that were needed. This continued throughout the year. For example, at one point we needed 1,000 gowns every day and similarly when the Government announced new guidance recommending that all staff wear a surgical mask in hospital at all times from Monday 15 June, nearly 20,000 masks were used per day in the first week alone.

Our teams played a significant role in supporting the NHS and the international healthcare community to learn more about the virus. By May 2020, over 100 patients at East Surrey Hospital had been recruited to the RECOVERY trial – the largest global research study to find treatments for COVID. In total, SASH participated in 10 Department of Health Urgent Public Health Research Studies, as well as four other COVID studies, including one led by our Trust. We recruited 2,410 patients into these studies which was vital in helping with the national COVID response as well as being able to offer the latest treatments to our patients.

In December 2020 we reached a significant landmark when we were able to offer self-testing kits for all of our staff to use twice a week. This helped to identify infections earlier – particularly those people who had the virus without displaying symptoms.

By January 2021, over 1,000 people cared for as inpatients with COVID-19 at East Surrey Hospital had already recovered enough to be discharged, but the second and largest peak was just approaching. The start of the new calendar year saw a significant increase in patients with COVID-19 across the country, and this coincided with the highest numbers we saw at SASH too.

With the number of inpatients with COVID-19 at East Surrey Hospital rising to over 200, the armed forces provided support so that SASH staff could focus on clinical care. At the same time, our One Team continued to support each other. Many staff who usually work in support services volunteered to support wards with tasks such as supporting patients to have video calls with their family and friends.

During this peak, the beginning of the COVID-vaccination programme offered welcome hope and optimism. While dealing with the second peak of our response, our teams designed and delivered a COVID-vaccination service to protect health and care workers from the virus with over 9,200 doses given at East Surrey Hospital.

Throughout the year, the support received from the local community and our partner organisations was extraordinary. The messages of support and encouragement meant more to our teams than many people will realise, and the generosity of our community was hugely appreciated – this is covered in more detail in the section on

SASH Charity later in this publication. It continues to help with our efforts to support the wellbeing of our staff which is of paramount importance given what they have been through this year.

The thoughts of everyone at SASH are with our patients, our friends, our relatives and our colleagues who lost their lives during the year.

Seeing the first empty box that had contained vaccines for more than 1000 people was an emotional moment that will stay with me for a long time.
Joanne Rhodes, chief pharmacist

This pandemic has brought us closer together with everyone helping each other. All the love, support and kindness from our communities was inspiring and will never be forgotten; they let us feel more valued.
Mina Dris-Harrid, ward manager

I have never felt prouder to work for the NHS as I have this past year. What an incredible organisation of people working together no job too small, no person too insignificant.
Dr Claire Mearns, consultant anaesthetist and intensivist, lead for critical care

I really wanted to help in some way and was so happy that I could do that by volunteering. The patient facetime calls are a lovely way to be able to ease the pressure for the staff on the wards. The feedback from family and patients is really lovely and they are so grateful to be able to see each other. If it was one of my loved ones I would be so pleased that this service is available.
Rebecca Gooding, Procurement

SASH+ - transforming care

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

Over the six years SASH, along with four other Trusts have been working in partnership with the Virginia Mason Institute (VMI) in Seattle, USA who have developed a transformational management system - the Virginia Mason Production System, which is based on lean methodological improvement techniques adopted and adapted from the Toyota car manufacturing factory in Japan. Over the last 20 years the Virginia Mason Production System has enabled them to become one of the safest and highest rated hospital organisations in the USA.

Our aim at SASH is to pursue perfection, putting our patients at the forefront of everything we do, improving safety and quality by reducing variation and waste in every process. SASH+ is defined as a management system with an inbuilt quality improvement methodology enabling kaizen to happen every day. Our SASH+ work supports an accelerated transformation in quality by providing us with a structured approach to continue our improvement journey and has helped to take us from being a CQC rated "good" to an "outstanding" organisation.

Our Kaizen Promotion Office (KPO) team lead SASH+; providing the structure, methods and rigor behind the successful implementation of our management system, alongside training and developing staff from across the organisation to lead using their new skills and methods.

Education and training

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

Kaizen and COVID

Over the last year the team have been deployed across the Trust using SASH+ principles to design, develop and to respond to issues which have been highlighted by COVID-19.

The team designed and implemented a process for the receipt, allocation, training and reporting of lateral flow tests for 5500 trust staff, students, on site contractors, maternity patients and their partners. They also developed a process for the effective management of FFP3 face masks, powered air respirator packs and non-powered respirators which included the stock management, allocation, training, decontamination and maintenance of more than 250 items. The process ensured that staff had 24/7 access to effective PPE which was decontaminated after use and always kept in good working order.

In addition to these developments the team have also worked in the following areas:-

- Designing and delivering a responsive family liaison service for patients in intensive care
- Developing an IV antibiotics reconstitution service which provided access to anti biotics in a more timely way
- Developing and implementing a clinical support hub which enabled non clinical staff to support clinical areas
- Implementing a safe process for the decontamination and re-use of single use gowns

- Designing and developing a COVID vaccination service which ensured a high quality responsive service was provided with no queues
- Revising our patients' property processes to support the delivery of property to patients on wards when visiting by relatives was restricted
- Designing the delivery and allocation of portable oxygen cylinders with clear transparent processes for usage, delivery, cleaning and return
- Reporting of COVID results to patients who had been discharged from the hospital
- Distributing gifts and donations to staff across the hospital

We are very proud of the significant and sustainable transformation changes we have successfully made and look forward to continuing to improve the high quality of care we provide to local people.

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

Our governors and members

Governors provide valuable insight and feedback from the members they represent. They work with, represent and are conduits to the members of their constituencies, helping the Trust to understand the needs and experience of patients and local people; in effect, by making sure 'patients are always in the room' when services are being discussed and decisions made.

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

The governors are elected by members of the constituency of which they are a member and which they represent. The Council of Governors include elected public, patient and staff governors, along with nominated governors from our partner organisations.

Our governors are volunteers and unpaid, and Council of Governors meetings are held four times a year in normal circumstances. Governors are also members of sub-group and working meetings, on specific issues, for example patient experience, end of life care, patient information and community engagement events as well as being part of our annual general meeting.

This financial year has been significantly challenging. As the Trust has focussed on the pandemic response there has been less focus on strategic work and less resource to support the Council of Governors. The Council has met twice in the last 12 months, virtually, as well as maintaining activity in other Trust Governance Forums such as the Patient Experience Committee. It has been challenging to support engagement activity with social distancing and travel restrictions limiting opportunities to meet. The Trust and the Council of Governors are expecting a full and active year in 2021-22.

The Trust has around 10,000 members, 5,000 from its patient and public constituencies and 5,000 from its staff. The membership constituencies are:

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

Although originally created as part of the process to become a foundation trust, the Trust Board made the decision to retain an elected council of governors and recruit patient and public members. The Council of Governors remains constituted and active however it does not have equivalent statutory responsibilities to those of a foundation trust. It acts as a trusted critical friend to the Trust and plays an important role in the development and embedding of patient and public engagement throughout the organisation.

One of the innovative developments the governors have continued to lead over the last couple of years is the quarterly governor newsletter which raises the profile of the work of and contribution of our governors.

This is shared widely through the Trust with our members and available on our website.

SASH Charity

SASH Charity raises funds to help the Trust go above and beyond what would otherwise be possible, to deliver great experiences for SASH patients and staff.

2020/21 brought extraordinary challenges for NHS staff and the whole community, and alongside its normal work, the Charity helped to channel high levels of support from the public for NHS staff working through the pandemic.

The Trust and the Charity are deeply grateful for this support, which has taken many forms, and been valued enormously by staff.

To help channel this support, the Charity established a Staff Welfare focussed appeal to help staff through (and beyond) the pandemic. Thanks to support from our community, and from fundraising nationally for NHS Charities Together, SASH Charity was able to respond to urgent requests from staff, for example sleep and wellbeing packs for colleagues, and to create new or enhanced facilities (notably a new staff wellbeing room at East Surrey Hospital). At a time when visiting restrictions were required, the Charity was also able to fund new tablet computers for every ward in the Trust to enable patients to have video calls with loved ones. These provided a vital link for family members through the peak of the pandemic and will continue to be used.

The Charity supported vital work to understand the psychological impact on staff of their work through COVID-19, and individual and group counselling sessions with a trained psychologist. Work has also commenced to design and create new and enhanced rest areas for staff at East Surrey Hospital, as well as to enhance staff rooms at all other sites from which we deliver services. These will be delivered in 2021.

Olive's Appeal
2020/21 was the first full year of the Charity's neonatal unit appeal, which achieved a number of milestones despite the pandemic. Notably through funding the first three of a target of five state-of-the-art incubators, as well as funding rainforest themed wall coverings throughout the new unit, and creating a new room for parents and siblings of babies in the neonatal unit.

Team and systems
The Charity continued to develop its systems in line with its strategy. Key developments included the appointment of a second member of staff, to the new role of Fundraising Officer, and the implementation of the Charity's first Customer Relationship Management (CRM) system. These developments will help the Charity to thank and engage with supporters more effectively; a vital building block for the future development of the Charity.

Supporting patients and staff across SASH
Alongside work directly related to COVID-19, staff welfare, and Olive' Appeal, the Charity continued to respond to requests for charitable funding from staff across SASH. Thanks to donations, the Charity was able to fund a broad range of projects across the organisation. The full list is available on the charity website www.sashcharity.org and highlights included:

- An exhibition of illustrations on the symptoms and impact of Parkinson's Disease by artist and A&E consultant Jonny Acheson.
- Improvements to a radiology waiting area for children at Crawley Hospital.
- The launch of a Reverse Mentoring programme, through which members of staff, often from Black or Minority Ethinic backgrounds, are supported to mentor senior leaders.
- Funding the launch and materials relating to the Safe SASH campaign which brings focus to the Trust's work to be a leader in patient safety.
- Specialist books to help children facing the loss of a parent.

The Charity continues to develop, thanks to the support of staff at SASH, and our community. The Charity and Trust would like to thank everybody who has supported through this extraordinary year, including the Murray family, London Gatwick Airport and The Vinci Foundation, NHS Charities Together, Peter Harrison Foundation, and The Morrisons Foundation.

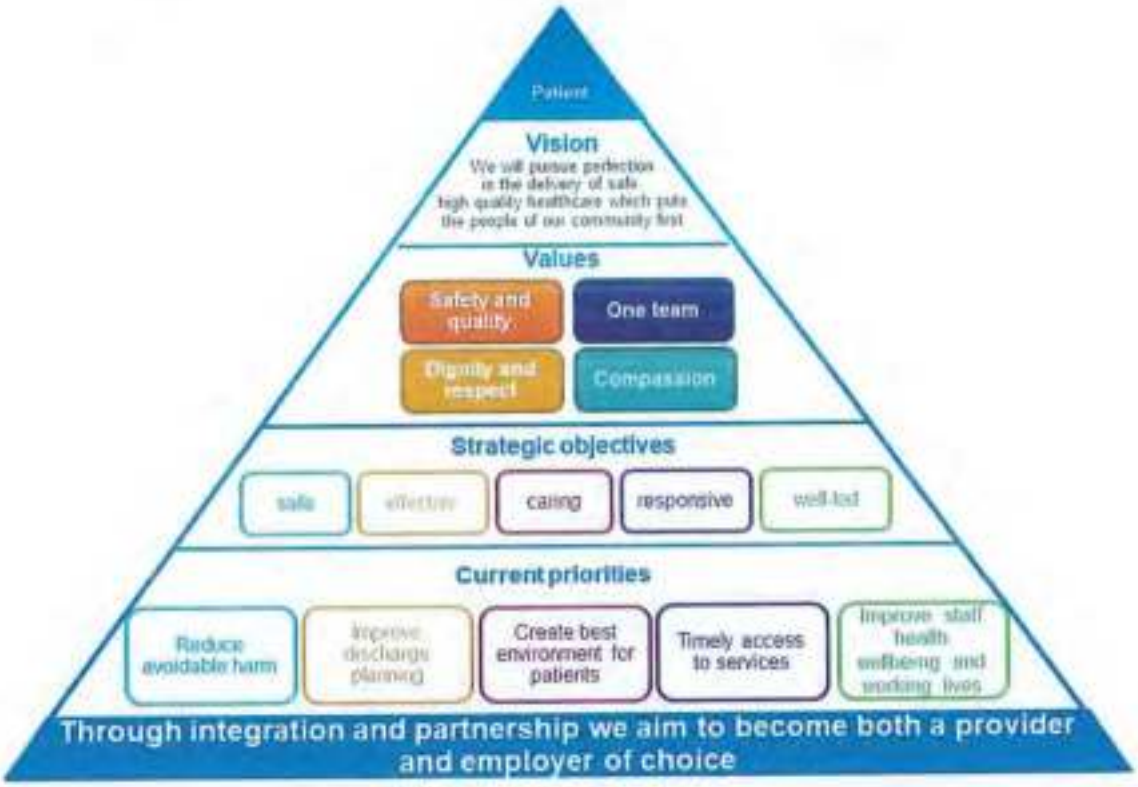
More information is available online at www.sashcharity.org.

Our strategy and plans

Our strategy has served us well in helping us to always focus on the patient and ensuring that our values are ever present in everything that we do.

2020/21 has been a year where our focus on **safety** has been paramount for both staff and patients; being **effective** in the development of new ways of working and new treatments has allowed us to keep many of our services accessible; our drive to be **caring** has seen us develop new support mechanisms for our patients and their families; we have been **responsive** to a whole range of factors never before witnessed within the lifetime of the NHS; and, perhaps most of all, this last year has required strong and supportive **leadership** to ensure that we have been able to flex our approach to the many challenges we faced and look after our staff who worked under the most trying of conditions.

Our strategy on a page outlines our vision, values, strategic objectives and current priorities.



Our strategic objectives are:

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

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

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

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

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

Delivery of our current priorities

Throughout this extraordinary year, we have delivered against our current priorities. The bullet points below demonstrate just some of the ways we have done this.

Safe: Reduce avoidable harm

- We deployed a consistent approach to infection prevention and control throughout the year, embracing new equipment and PPE for staff, purchasing new technology to increase the speed and effectiveness of cleaning and using clinical expertise to inform how we worked and adapted to ensure highest levels of safety for staff and patients.
- We introduced new ways of working to reduce incidence of pressure damage.
- We've placed significant focus on implementing the national patient safety strategy, with teams across the organisation developing pledges and each division devising safety goals which will guide our work throughout 2021/22. You can read more about this in our Quality Account.

Effective: Improve discharge planning

- During the year additional funds were set aside to smooth discharge pathways. This had a major impact on the reduction in bureaucracy and the speed at which patients are able to be either discharged home with support or discharged to another setting with the right levels of support.
- The discharge unit was redesigned and pathways changed to ease the process for patients leaving hospital.

Caring: Create best environment for patients

- Like all hospitals, restrictions to patient visiting were necessary this year. We responded to the challenges this brought by implementing a family liaison team to support communications with relatives of patients in intensive care, implemented bookable video calls for patients and their families and set up an email for messages to be printed off and taken to patients from their families and friends.
- We implemented social distancing throughout all of our services including changing the number of beds on wards, adapting waiting areas, introducing screens and ensuring that PPE was available to all that needed it.
- Our chaplaincy team supported c.800 families and many of our teams in the last year to cope with the challenges of the pandemic; the feedback suggests this was unexpected but incredibly caring and well received.

Responsive: Timely access to services

- We implemented virtual and digital solutions to make sure we could be as responsive as possible. This included telephone consultations, video consultations, digital governance meetings and supporting some staff to work from home where possible and appropriate.
- We undertook significant work to ensure that sufficient oxygen was available to treat our patients. This was necessary as the numbers of patients needing oxygen increased, making access to sufficient levels of oxygen a real issue in the inpatient setting.

- We relocated our Same Day Emergency Care service to new facilities, in a better location to increase access. This results in more patients being able to access a swift and effective assessment that aims to treat and discharge as much as possible, helping patients to avoid unnecessary stays in hospital.
- We purchased additional CT scanners to replace old equipment and also to respond to the increasing demand for diagnostics.

Well led: Improve staff health, wellbeing and working lives

- The health and wellbeing of our workforce has been one of the single biggest priorities of the year, resulting in a suite of services and support mechanisms being put in place which is described elsewhere within this annual report.
- Many staff were absent at various points due to COVID. At the same time a number of staff needed to shield; colleagues have worked extremely hard either in different ways or in new roles during this period. People across the organisation have continued to support those for whom other adjustments or requirements were needed.
- Following the emerging evidence of the effects of COVID on different groups, we have reviewed how we make inclusion central to everything we do, to ensure we provide a fair and equal environment for all of our staff.
- We have worked closely with our local partners and our system partners to work collectively on our approach to managing the pandemic and to ensure our services could be sustained.

Working in partnership

We continued to work together with colleagues in the Surrey Heartlands Health and Care Partnership and the Sussex Health and Care Partnership integrated care systems. We are now part of two integrated care systems and the delivery of health and care services to our local population relies on good partnership working, so we are proud to play our part in the development of these systems. We are an integral part of those arrangements and looking forward to the changes coming in April 2022 when the law will be changed to provide a stronger basis for integration of care across the NHS.

With local primary care networks and other partners, we have worked collectively to improve care for local people and implement service that will improve the health of the population. For example, we have worked together to create frailty hubs, with professionals from across health and social care forming local teams to systematically review the support needed for people who are frail or developing frailty. This approach wraps care and support around the patient, slowing the progression of frailty, reducing any gaps in service and helping get support to people proactively, before they need urgent or emergency care. As the systems and structures develop further we will endeavour to expand these kinds of approaches to benefit patients.

We have also collaborated with other local providers. For example we brought together over 40 experts from our Trust and Surrey and Borders Partnership NHS Foundation Trust (SABP) for a joint integrated care improvement and visioning event. They collaborated every day over the course of a week to plan how services can improve now and in the future with a series of actions being developed as a result. We are also working with SABP on the consideration of building a mental health unit on the East Surrey site as part of SABP's reprovision of its services.

In 2021/22 we will be looking to implement a new pathology partnership by joining Berkshire and Surrey Pathology Services. During the year we considered and approved plans that will see us join the network and we believe this will lead to a more certain, stable and sustainable situation for pathology services at SASH and the local care system. It will deliver speedier access to modern technology to deliver state-of-the-art diagnostics; clinical benefit to patients by aligning the pathology service to existing clinical networks and care pathways; and a larger critical mass to ensure resources and expertise are maximised.

On our East Surrey site we continue to work in partnership with Guys and St Thomas' NHS Foundation Trust (GSTT) who provide a respiratory centre, Royal Surrey County Hospital NHS Foundation Trust (RSCH) who provide radiotherapy and other cancer services and the MacMillan charity who provide cancer support services.

Our ability to deliver our plans

Performance appraisal

Our performance analysis overleaf, as well as our Annual Governance Statement, provides a more detailed account of our performance over the course of the year and the key issues and risks.

In summary, in emergency care we have maintained strong performance, benchmarking among the best trusts in the country. Looking ahead, we regularly monitor forecast changes in demand to enable us to plan to continue this strong performance.

As described in more detail overleaf, the COVID-19 pandemic caused a number of challenges to our ability to deliver against the national standards for cancer waiting times, referral to treatment waiting times and diagnostic performance. We continued to provide the most time-critical surgery during the pandemic and clinicians prioritised care according to urgency. We have plans in place to do more work than ever before in order to see patients as soon as we can in the months ahead. We have already made good progress with this work.

Going Concern

The key determinant (as set out in the 2020/21 DHSC group Accounting Manual) for the application of the Going Concern basis in the preparation of the Trust's accounts for 2020/21is whether services currently provided by SASH will continue to be provided. The Board of Directors have agreed the following statement to support the adoption of the going concern basis for the Trust's 2020/21 annual accounts:

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The Trust has therefore concluded that the going concern basis is appropriate for the preparation of its 2021/21 annual accounts.

Performance analysis

Purpose

This section provides more detail on our performance during the year and how we measure that performance. You can find information on the demand on our services, patient experience, how we develop our people and equality and diversity. Our financial analysis is included in a dedicated section later in this report.

Activity - the numbers

Activity this year

	2018-19	2019-20	2020-21	Change	% Change
Emergency Attendances	105,325	112,534	91,922	-20,612	-18.32%
Outpatient Appointments	396,709	407,499	350,647	-56,852	-13.95%
Non-Elective Admissions	38,376	39,646	33,062	-6,584	-16.61%
Births	4,492	4,460	4,396	-64	-1.43%
Elective Admissions	52,332	53,307	34,687	-18,620	-34.93%

Performance against national standards

	Standard	2018/19	2019/20	2020/21
ED 95% in 4 hours - LAEDB Performance	95%	96%	92%	96.9%
ED 95% in 4 hours - Trust Performance	95%	93%	90%	94.6%
Patients waiting in ED for over 12 hours following DTA	0	0	0	0
Cancer - TWR	93%	94%	92%	98.70%
Cancer - 62 Day Referral to Treatment Standard	85%	82%	76%	77.20%
RTT Incomplete Pathways - % under 18 weeks	92%	91%		
RTT Incomplete Pathways - No of Patients Over 52 Weeks	0	9	15	728

Monthly access to services

	Q1			Q2			Q3			Q4		
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
ED 95% in 4 hours - LAEDB Performance												
ED 95% in 4 hours - Trust Performance												
Patients waiting in ED for over 12 hours following DTA												
Ambulance Turnaround - Number Over 60 mins												
Cancer - TWR												
Cancer - 62 Day Referral to Treatment Standard												
RTT Incomplete Pathways - % under 18 weeks												
RTT Incomplete Pathways - No of Patients Over 52 Weeks												
Percentage of patients waiting 6 weeks or more for diagnostic												
No of operations cancelled on the day not treated within 28 days												

* We are one of the trusts across England taking part in the field testing of the proposed new elective care standard for RTT. During this time we will not be publishing performance data for the RTT standard.

A&E: four-hour standard

During the pandemic, our emergency department continued to be very busy. Understandably new protocols had to be put in place to safely care for people with suspected coronavirus, and at the same time people continued to attend the department for other conditions.

Despite the various stages of lockdown with many more people staying indoors, we still saw over 90,000 people come through the doors of our emergency department. The national standard to measure our performance is that 95% of patients should be seen and either admitted or discharged within 4 hours. In keeping with the rest of the NHS, the trust was challenged, particularly in the second half of the year, to meet the national standard of 95%. With our performance at 94.6%, we benchmarked among the best performers in the country. This meant that despite the challenges that COVID-19 presented to emergency services nine out of every 10 patients were seen and admitted or discharged within the national standard of four hours.

We worked hard to organise our services in a way that would support teams across the hospital to keep patients with suspected COVID separate from those being treated for other conditions. This involved a major reorganisation, increasing the footprint of our emergency department and our same day emergency care department. At the same time we created separate pathways in each specialty across the hospital to help make sure we admitted patients to the safest place as early as possible. All of this work contributed to our strong performance.

COVID-19 caused significant clinical and operational challenges which involved the reconfiguration of our hospital inpatient wards and staff being redeployed to support intensive care services. Fortunately, now we have been able to return most of our wards to their original state with most of the staff returning to their original place of work.

ICU capacity was tripled in the height of the pandemic such that we had to utilise one of our wards making it unavailable for normal adult capacity. In addition, demand for ICU beds was such we had to transfer a number of patients to other units during the height of the pandemic over winter. We would like to thank all of our colleagues in other hospitals, in Surrey Heartlands ICS and in South East Coast Ambulance Service NHS Foundation Trust (SECAMB) who supported us in ensuring that every patient was able to access an ICU bed that needed one.

Performance against the emergency care standard remains a priority and it relies on work not only across SASH but across the whole of the health and care system. We worked closely with colleagues across the system to ensure patients were managed safely in light of COVID-19 and we will continue to do this into 2021/22.

Cancer waiting times

In 11 out of the 12 months of the year we met the national standard of 93% of patients being seen by a specialist within two weeks of their urgent GP referral.

However, we saw a number of challenges in our ability to deliver against the standard which aims to ensure that 85% of patients begin their first definitive cancer treatment within 62 days of their urgent GP referral. There was a significant rise in the number of people awaiting diagnosis for possible cancer which continued throughout the year and remains an ongoing challenge. Whilst many of those patients will not have a cancer any that do will be treated with the utmost urgency. As we start to treat these patients on their pathway the performance will drop before it improves as more patients are treated. This situation is reflected across the country.

Some of these challenges were related to the availability of staff, with many surgical teams redeployed to different areas at various points of the pandemic and unprecedented levels of staff sickness. During this time we continued to prioritise the most time critical treatments in line with national guidance, reviewing each patient's case carefully. We worked incredibly hard to rapidly increase capacity as staffing allowed in order to speed up treatment for people who had been waiting longer than we would have liked. Looking ahead, this continues to be a priority. We will ensure our meticulous approach to reviewing patients' clinical needs continues, while maximising our ability to see patients as quickly as we can by working collaboratively with health and care partners.

Referral to treatment standard

The main standard for routine care is currently that 92% of people waiting for planned treatment should be waiting less than 18 weeks from the time of their referral. In line with every hospital in the country we were asked to suspend all but very urgent elective operations to help us to provide the right response to COVID-19. Whilst very urgent operations continued and as many appointments as possible were conducted over the telephone or via virtual video links we were required to postpone a significant number of operations, procedures and appointments.

This has meant that over the last 12 months the number of patients waiting for a planned treatment has increased with over 800 patients waiting over 52 weeks by the end of February 2021. This is in line with the experience across the country.

During the year we worked with local independent sector providers to ensure we could provide treatment for patients needing urgent or cancer care. We have contacted all patients who are waiting for planned treatment and are now working to ensure that each patient has a date for their treatment as quickly as possible. Towards the end of the year we made good progress to reduce the number of patients waiting longest for treatment, with plans in place to do more work than ever before to see people as quickly as possible.

Managing risk

Our Annual Governance Statement sets out in detail our approach to managing risk at the Trust. This statement shows that the reduction of elective work in outpatients, surgery, cancer and diagnostics due to COVID-19, and the subsequent rise in the number of patients waiting for treatment, was the one red-rated risk recorded in our Board Assurance Framework. The Board Assurance Framework, which is available on our website, sets out our mitigating actions we took related to this risk. As the narrative in our performance section above explains, these actions include clinically reviewing patients to ensure a focus on clinically urgent cases and those waiting longest, producing new standard operating procedures to ensure time-critical cases could continue during the pandemic, working with private-sector providers to increase our capacity for elective activity and working with system partners to ensure support across the region. This risk will continue to have an impact into 2021/22 and our performance narrative sets out some of the actions we are taking to mitigate the impact.

Looking ahead: future performance

In 2021/22 we will look to build on the significant work undertaken over recent months to transform our outpatient services. Over 17,500 appointments took place online in 2020/21, up from just 130 in the previous year. This is a truly transformational shift and we are grateful for the huge work our teams put in to make it possible (not least those teams who work behind the scenes at SASH). Of course the catalyst for this change was the pandemic and as we recover our focus is on making sure our enhanced technological capabilities continue to help those for whom online appointments are beneficial, while ensuring people can still attend face to face appointments when they need to.

Over the last year we invested in creating new space to see people face-to-face for outpatient appointments which will help these efforts looking forward. At the same time we strengthened relationships with partners during the pandemic, for example working closely to support care homes. This will stand us in good stead to respond to the needs of our community in the months ahead.

We have plans in place to make sure patients waiting for planned surgery can be seen as quickly as possible. With staff now back in their usual places of work, we will be maximising our capacity in the months ahead with additional surgical lists running when possible. We have learnt a great deal during the pandemic about maintaining a 'cold' pathway for planned surgery, with patients systematically screened before they arrive for their operation and then kept separate from the rest of the hospital.

Up and down the country the pandemic shone a light on some of the health inequalities that still exist. We have revised our Access and Responsiveness Committee which will monitor our work to restore urgent and elective pathways, whilst providing enhanced oversight of our significant efforts to ensure equality of access to our services. The Committee will play a key role in making sure the needs

and experience of particular groups within our community are understood and truly shape the development of our services.

We have described some of the risks and challenges to our performance that we have experienced over the year. You can read more detail about our risk profile in our annual governance statement included within this report.

Financial performance review

Please see the 'Our Finances' section of this report.

Patient experience

What our patients say

The extraordinary circumstances of the last year have provided a challenging environment for patients, their families and staff. Like all hospitals, the pandemic meant we needed to put some restrictions on the number of visitors to our hospital sites. Throughout the year, we were proud to continue to facilitate visits for people in exceptional circumstances – particularly those at the end of their life and those for whom the presence of a visitor is crucial to their care. This might include a person living with dementia, a patient with a learning disability or someone with a mental health issue.

At the same time, the restrictions that we put in place provided a catalyst for our staff and patients to find new ways to communicate and deliver care.

The Trust looked for practical and creative ways to ensure that patients and their families felt connected. The Trust established a Patient Liaison Team in the Intensive Care Unit (ICU) to keep families in touch with the most seriously ill patients and give regular updates on their progress. Tablets were donated to the Trust for use in ICU and across the wards to keep patients in visual contact with their families. Direct dial lines were installed in every ward to simplify the process of calling for updates. The use of "cards of kindness" has proved popular, whereby the next of kin can send messages to their loved one, written on a card which can be read out and kept.

Matron Natalie Burling and the team on the Integrated Reablement Unit (IRU) were shortlisted for a prestigious Nursing Times award in the category of 'care of older people'. During the height of the COVID-19 pandemic, the team did all they could to enable people to visit loved-ones in the right circumstances. However, like the rest of the NHS we had to restrict visiting to help us prevent the spread of infection. Recognising the importance of keeping in touch with relatives and carers, the team came up with a simple visual checklist to make sure loved-ones were called daily by members of the clinical team. The checklist ensured it was immediately obvious to

any member of the team when a relative or carer was last contacted. This helped us to provide consistent and regular communications from a variety of team members. Keeping loved ones informed in such difficult circumstances was vital, so many of our other teams implemented the idea as well. When a photo of the idea was posted on Twitter, dozens of other organisations responded to say they would be adopting it too. This is a superb example of how a visual cue can help us improve services and another great illustration of our SASH+ work in action.

As the footfall within the Trust reduced, and in line with national advice regarding social distancing, the Trust closed the Patient Advice and Liaison Service (PALS) office to personal callers. The team continued to liaise with patients and their families via e-mail and telephone.

The revisions to the National Friends and Family test (FFT) were implemented in April 2020; patients are now asked the question 'Overall, how was your experience of our service?' The Trust has continued to solicit patient experience feedback throughout the pandemic via our digital platforms but overall there have been fewer responses which is reflective of the lower level of elective activity. Data submission and publication for FFT was paused from April 2020 to January 2021 by NHS England. Despite the lower number of responses, the proportion of users stating that their experience of our services has been good or very good remains broadly static.

As the Trust returns to normal activity the priority for the coming year will be to publish a Patient Experience Strategy for the Trust. In addition we will review the Your Care Matters survey to ensure that the questions are relevant and inform the quality improvement initiatives across the Trust. We will provide visible evidence in public places to demonstrate what actions have taken place because of feedback.

Our Patient Advice and Liaison Service have just over 400 contacts per month, offering practical solutions and a listening ear in real time. Contacts are made via walk-ins, telephone, letters and emails. PALS intervene so that potential reasons to complain can be managed proactively. The PALS team record all the contacts on the DATIX system, which then allows monthly reports to be presented at the Patient Experience Committee, highlighting the trends and issues.

Making it better - responding to complaints

In 2020/21, 417 complaints were reported to the Trust Board, compared with 590 in 2019/20. A total of 70.2% of formal complaints were responded to within the timescale agreed with the complainant.

Of the complaints received in 2020/21, 15 resulted in a dissatisfied response from the complainant. This compares favourably with the 40 recorded for the previous financial year. Dissatisfaction with complaints responses is necessarily measured in

arrears because we need to allow people time to respond; full year data will be published in our annual complaints report later in 2021.

At the beginning of the 2020/21 financial year the Trust undertook to renew the focus on reducing our response time for complaints. We introduced a new Key Performance Indicator (KPI) to monitor the timely resolution of complaints. The Trust aspiration is to respond to all complainants within 25 working days. Taking account of more complex cases, we set the target at 95% of responses within 25 working days of receipt.

However, the priority for frontline staff over the past year has been the delivery of safe care to patients. Complex activity in difficult working conditions with reduced staffing levels has reduced the administration time available for the timely completion of complaint investigations. As a consequence this metric has not been met in the year. The Trust remains committed to this target and we expect to see an incremental improvement through 2021/22.

Social distancing and lockdown has also impacted the number of meetings that the Trust could organise with complainants to discuss and resolve concerns. While unavoidable, the Trust places great value on the opportunity to hear the experience of service users first hand. During the past year clinical teams have been encouraged, where possible, to telephone complainants on receipt of the complaint to understand the circumstances of the complaint. This has helped to establish a positive and personal relationship with complainants.

A normal benchmark of the quality of our complaints process would be the number of times that completed responses are referred to the Parliamentary and Health Service Ombudsman (PHSO) for review, and the outcome of those reviews. On 26 March 2020 the PHSO took the difficult decision to stop accepting new cases relating to NHS services. Ongoing cases were put on hold. This ensured that NHS resources could focus on the pandemic response. The PHSO are now accepting referrals but the Trust has paused reporting this metric in 2020/21.

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2021.

Our people

COVID-19 has affected many of the initiatives we usually run for our staff and our local community. Many of these, including the SASH Star Awards, our volunteers programme, work experience, gender pay gap reporting, and the staff friends and family test, would usually be included in this section of our Annual Report.

We have however had a more specific requirement to further support the wellbeing and welfare of our staff during the past 12 months given the challenges many have faced that they would never have expected.

The impact of COVID has been felt across all staff but within certain demographics this has been heightened. Whilst an incredibly challenging time, this has fostered an even closer working relationship between colleagues at the Trust and an even closer positive relationship with Staff Side (our union representatives).

Who we are

We have a workforce of over 4940 people in a broad range of clinically registered professions and support roles and we value everyone for the part they play in delivering high quality care to our patients through our One Team approach.

Our Team is made up of the following professions:

	Headcount	% of Workforce	% Female	% Male
Add Prof Scientific and Technic	148	2.99	77.70	22.30
Additional Clinical Services	900	18.19	75.89	24.11
Administrative and Clerical	933	18.86	83.28	16.72
Allied Health Professionals	248	5.01	76.61	23.39
Estates and Ancillary	408	8.25	44.61	55.39
Healthcare Scientists	88	1.78	67.05	32.95
Medical and Dental	723	14.61	51.04	48.96
Nursing and Midwifery Registered	1496	30.23	88.70	11.30
Students	4	0.08	75.00	25.00
Grand Total	**4948**			

Staff survey

National NHS Staff Survey

We received a fantastic response to the 2020 National NHS Staff Survey – over 65% of staff completed the survey and our results were equally impressive.

Of the ten Key Themes we scored among the highest 20% in eight, with improved scores from the previous year in five. We scored highest nationally for staff looking

forward to attending work and we were the fourth highest ranked trust for staff recommending the organisation as a place to work.

We have seen our score for Safe Environment (Violence) improve from 2019. Whilst this score is still below the national average, it is pleasing to note that the interventions the Trust has made over the past twelve months have been recognised by our staff and they feel safer in their work place than in previous years.

The key area for SASH to address is in regard to inclusion where our score has decreased from the previous year. We established and appointed to a new post of Head of Inclusion in January 2021 and we will ensure that we implement interventions that recognise the requirements of staff in developing a fully inclusive culture at SASH.

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

The table below sets out our scores in the ten key themes and the full results for the Trust are available on the national staff survey website.

Key Theme	SASH 2019 Score	SASH 2020 Score	Statistical Change (2019 to 2020)	2020 Best Nationally	2020 Average Nationally
Equality, Diversity & Inclusion	9.1	8.9	Significant (lower)	9.5	9.1
Health & Well-being	6.4	6.5	Not significant	6.9	6.1
Immediate Managers	7.2	7.2	Not significant	7.3	6.8
Morale	6.4	6.5	Not significant	6.9	6.2
Quality of Care	7.8	7.8	Not significant	8.1	7.5
Safe environment Bullying & Harassment	8.1	8.2	Not significant	8.7	8.1
Safe environment Violence	9.3	9.4	Not significant	9.8	9.5
Safety Culture	7.1	7.2	Not significant	7.4	6.8
Staff Engagement	7.5	7.5	Not significant	7.6	7.0
Team Working	7.0	7.0	Not significant	7.1	6.5

"I am very proud that our staff rate us among the best in the country. Our teams have been through so much this year, so it has never been more important to make the NHS the best place to work."
Michael Wilson CBE, chief executive

Developing our staff

We have continued to progress workstreams to support the implementation of the education and development strategy and operational plan. Five education objectives provide the framework for the underpinning operational delivery plan aligned with SASH's strategic objectives.

Whilst activity has continued between the peaks in clinical activity, COVID has had a significant impact on the way in which education and development has been delivered over the past year.

In order to ensure continuity for business critical activities such as induction and mandatory training updates, content was transitioned quickly into video, virtual and e-learning formats. A significant amount of work was undertaken early in the year to support subject matter expects to record content in video format so this could be delivered virtually and via SASHnet. Additionally work was undertaken to provide bank workers with access to induction training prior to deployment via the Cortex system. This collaborative approach enabled a rapid change to the face to face training which pre-COVID was the main mechanism for bank workers to access their induction training. Later in the year we introduced google forms to capture feedback from learners as a basis for importing their experience from the initial transition phase to virtual delivery. Mandatory training compliance has remained broadly stable at 85% despite the disruption to the planned training schedule as result of the transition to a virtual format.

Whilst essential training continued throughout the year, some internal leadership and professional development programmes were paused or delayed. In order to re-start programmes following the first COVID surge, work was undertaken to transform workshop-based sessions into blended formats. The challenge with this style of learning is to maintain the high levels of interaction. An external company was commissioned to provide upskilling for internal trainers and facilitators which was well received.

Three staff were trained as facilitators to deliver 'Mary Seacole Local' and NHS Leadership Academy endorsed courses. The first cohort of new leaders in clinical roles such as ward managers commenced in February 2021 and a second cohort is planned for September 2021. This programme builds on the current leadership development for staff in more junior roles.

The Trust's Organisational Development Facilitator gained accreditation to use the Affina Team Journey (ATJ) tool – a 10 stage framework for team leaders to use to develop their teams to work more effectively. A pilot took place with the ATJ coach working directly with the Clinical Lead for Paediatrics. Plans are in progress to adapt the way in which we use the ATJ tool to increase the scale and reach of the toolkit. Rather than one to one coaching of team leaders, a series of workshops will be delivered to a cohort of team leaders to upskill them to use the ATJ toolkit with their teams, with support from the ATJ coach where needed.

Nursing, midwifery and allied health professional staff were able to access new Continuing Professional Development (CPD) funding. This is an allocation of £1000

per staff member over a period of 3 years. At the beginning of the year a training needs analysis was conducted to develop a forecast of the external and internal demand for courses aligned to development and future workforce needs. This helped to inform bids for additional education funding particularly for those staff groups not included in the CPD allocation such as pharmacy, scientists and other non-clinical staff. SASH was able to secure funding via the ICS for key education work-streams. CPD for external courses has included post registration, specialist and advanced training on academic modules and pathways as well as short courses. Additionally the Women's and Children's Health (WACH) Division have accessed CPD funding to facilitate local training on specialist topics for midwives and other courses for a wider audience include, Human Factors, Tricky Conversations, Sage and Thyme and Root Cause Analysis.

A key area of focus this year has been our work with pre-registration students. In April 2020, the Nursing and Midwifery Council (NMC) emergency standards were introduced and students were invited to take up employment on paid placements to increase capacity to meet the clinical demands during the first COVID surge. This was implemented at a rapid pace and saw the first cohort of nursing students joining SASH on paid placement on 10 April 2020. SASH worked closely with Health Education England (HEE) and University partners to provide paid placements and support students to finish their training in this new model of working. The bravery and enthusiasm of students was an inspiration. Regular support sessions were facilitated with the Chief Nurse meeting students to discuss their experiences during this time. As a result of this model of working students developed a sense of belonging to SASH and many were recruited to substantive posts. Since that time SASH has been working closely with HEE and University partners to help provide additional placement capacity from September 2020 to enable students who missed placements during training earlier in the year to make up the practice hours needed to qualify.

SASH has implemented the new COVID risk assessments and provided access to lateral flow testing and vaccinations for all students. There has been really positive feedback from students about their experiences at SASH and the support they have received from our Clinical Support Facilitator and their supervisors and colleagues in practice. Supporting student placements for pre-registration training continues to be a critical activity to develop the pipeline for future healthcare professionals.

Apprenticeships have continued to be a key area of activity. Whilst there has been a need to facilitate breaks in learning for some staff and to temporarily pause some training during COVID pressures, uptake and progress has remained stable. This year has seen eighty colleagues commence study towards eleven different apprenticeships, comprising four non clinical and seven programmes which are clinical in nature. New programmes commenced in this year:

- Foundation Doctors Team Leading level 3
- Team Leading level 3 ILM
- Operations & Department Manager level 5 ILM
- Mammography Associate level 4

- Occupational Therapist level 6
- Property Maintenance Operative level 2

Responding to the recommendation to support training in leadership skills for newly qualified doctors, the Trust embarked upon a pilot scheme to offer foundation year doctors the opportunity to study a management apprenticeship. Twenty two FY1 doctors took up this offer and are currently studying towards this apprenticeship.

We have continued to support innovation through education; developing new roles such as Nursing Associate and Advanced Clinical Practitioner (ACP). The first cohort of Nursing Associates qualified and were registered in April 2020, followed by a second cohort in the autumn. A second cohort of trainee ACP's were supported to commence the apprenticeship education pathway in September 2020. Areas such as the emergency department, the acute medical unit, Paediatrics and Surgical Assessment have identified the ACP as part of their workforce plans to support future service delivery.

Twenty two apprentice colleagues successfully achieved their apprenticeship and related qualifications in this year.

COVID restrictions restricted work experience students joining for 'in person placements', and the SASH programme has been paused since February 2020. Working in collaboration with organisations across the Integrated Care System (ICS), three virtual work experience programmes were delivered during February 2021 half term encompassing; Medicine, Nursing and AHP. Managed by Springpod whom staged the virtual event and processed applications, 800 students from across Surrey, Sussex and Kent attended the programmes. The virtual realm provided the facility to give access to clinical procedures which may traditionally have been difficult to access and the opportunity to attend live webinars to gain insight from practitioners. Feedback from students has been extremely positive and the Trust was congratulated for making the sessions engaging and accessible. The Trust also supported five virtual webinar / career events, show casing SASH as an employer of choice. Participants shared experiences from Nursing, Physiotherapy, Occupational Therapy, Medicine, Property maintenance and Apprenticeships and Education in healthcare.

Orpheus centre – supported internships / work experience for young people with disabilities

SASH have participated in keep in touch career sessions with students from the Orpheus centre via MS teams, providing them with a chance to ask questions about opportunities and work experience at SASH.

Practice Development

The practice development (PD) team provide clinical training and contribute to the programme of career and leadership development activities for nursing assistants and registered nursing, midwifery and AHP staff. Non-essential training was paused

twice during the year, (from March - June 2020 and again from December 2020 - February 2021). During this time two members of the practice development team were re-deployed to support in the intensive care unit. Practice development colleagues provided essential refresher training to support staff that were returning to support the wards clinically during the COVID surges. Nearly 100 nurses accessed this training, with the team continuing to offer 1:1 refresher training when needed. Due to capacity and social distancing, many courses including preceptorship, springboard, nurse in charge, objective structured clinical examination (OSCE) preparation and IV update have all had to adapt and adopt a blended learning approach. The department has built a catalogue of training videos which staff can access directly. Due to the blended learning approach more nurses have benefitted from development than in 2019 despite the pausing of training for 5 months. Additionally, new training has been developed based on the emerging needs of our staff and patients, this included simulation sessions for nursing staff and the offer of a breakfast club where staff can access the PD team. The development and roll out of the medical devices competency was also achieved.

Staff engagement

Staff engagement has been crucial during the pandemic and it has supported the continued delivery of high quality, safe care to our patients in an uncertain environment. It is known that patient outcomes are better when there is an engaged and motivated staff.

Our staff engagement score in the 2020 national staff survey was one of the highest nationally among comparable acute trusts. We have a well-established network of different forums and mediums to engage with staff including:

- TeamTalk briefings hosted by the chief executive
- Chief executive's weekly message
- Annual NHS Staff Survey: The response rate for the Trust was 65% in 2020
- Regular meetings with trade union colleagues
- SASH+ improvement work
- Divisionally-led briefings and team meetings
- Freedom To Speak Up Guardian and ambassadors
- Guardian for safer working

Our established staff engagement strategy proved an incredible support during COVID, ensuring staff were kept up to date via regular COVID briefings, on line Team Talks, webinars supporting the vaccination and lateral flow programmes and BAME network events, amongst others.

Partnership working with our union / professional organisations

The Trust maintains a positive relationship with recognised trade unions and professional organisations and works collaboratively with them on matters regarding our people. Our long established Joint Partnership Agreement incorporates the statutory recognition and trade union facilities agreements and outlines the mutual commitments the Trust and our union colleagues make to working together.

Our Joint Negotiating and Consultative Committee and Local Negotiating Committee meet regularly and provide a proactive forum for unions and professional organisations representing all of our staff groups to come together to provide a healthy and collaborative two-way communication and resolve any concerns staff may have.

During COVID, the Trust worked very closely with Staff Side colleagues on a number of issues, including PPE, Risk Assessments, vaccinations, and staff well-being. Weekly meetings were arranged between the Director of OD & People and the Staff Side Chair so issues could be raised and resolved in a timely manner.

Equality diversity and human rights

In 2018 the Trust Board approved a three year One Team Inclusion Strategy which outlines our commitment to quality of opportunity and service delivery for the patients and communities we serve. Underpinned by the equality duty we are keen to ensure that inclusion is at the heart of everything we do. Our population covers a wide demographic, many of whom are seldom heard groups and underserved groups. It is important that we listen to and understand the needs of our community to ensure the services we offer to patients and visitors and our staff are appropriate and provided on an equal basis.
Our response to the responsibilities of the Equality Act 2010 and the Public Sector Equality Duty (PSED) is focused in the following ways:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

Our One Team Inclusion Strategy Includes the following mission statements:

SASH inclusion mission statements

- We are an organisation that is welcoming to all
- We will not tolerate any forms of discrimination and will challenge it wherever we see it, ensuring at SASH that equality, diversity and inclusion is everybody's business
- We will ensure that there are no barriers to accessing our services and achieving high quality outcomes for all. We will engage with our communities, in a bid to ensure we meet the needs of the people who use our services, with the aim of ensuring better outcomes for all, improve our patient access and experience
- We will take a preventative role to health by listening to our users, particularly those from **seldom heard** groups in our community (for example, the travelling community and people with learning disabilities)
- We will create a motivated and committed workforce, which enables talent to be recognised and rewarded regardless of demographic and celebrate the accomplishments of all our staff.
- We will act on feedback from our staff , so that we are better able to respond to create the best working conditions and foster the best working relationships, thereby continually improving the we way employ, support and retain a high quality diverse workforce
- We will develop interventions which help our staff to understand and support one another for the benefit of patients in our care
- We will work with partner organisations to reduce inequality within the Strategic Transformation Plan **footprint**
- We will set up an Inclusion Steering Group to ensure equality, diversity and inclusion are at the centre of all we do and that we are meeting relevant regulatory and mandatory equality requirements (i.e. Equality Act 2010 and public Sector Duty)
- We will ensure that the way we communicate with our staff, patients and visitors continues to be inclusive and equitable and share resources and develop initiatives for our diverse communities

The Trust has embedded a number of service developments to meet the needs of our patients and communities with protected characteristics some of which include:

The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) across the UK "Saving Mothers" lives annual report identified racial inequalities with Black pregnant women being five times more likely to die as a result of pregnancy than white women. Pregnant women with mixed ethnicity were found to be three times as likely as white women and Asian women twice as likely to die. Local data (albeit small numbers) demonstrated a similar disproportionate involvement of BAME pregnant women in adverse outcomes.

With the added impact of COVID-19 on the BAME population, the Maternity Service took the decision to ensure that its' COVID-19 recovery strategy included a focus on reducing the health inequalities experienced by these women. A proposal was successfully made to the ICS to review community midwifery accommodation in Surrey in order to create a Community Hub and thereby enable the service to provide targeted care for BAME women. A review of the local demographics identified that the BAME pregnant population was dispersed across Surrey making a community hub a key enabler to the implementation of continuity of carer.

Following engagement with BAME pregnant women and key stakeholders, two continuity of carer teams have been launched for BAME women recognising the benefits of this relational model of care. In the longer term this work will be replicated for BAME women in the Sussex area, prioritising BAME women who are non-English speaking or have other recognised co-morbidities such as Diabetes and obesity. This work has been shared with NHS England as a best practice model.

Dental decay is one of the most preventable diseases affecting children worldwide and the main reason a child is given a general anaesthetic in the United Kingdom. Difficulties in accessing appropriate dental care are particularly prevalent in marginalised communities within our population. Lack of stable accommodation, lack of awareness of available services, language barriers, fear of stigma and marginalisation due to background or ethnicity and distrust of institutions can all contribute to preventing timely access to dental care. These are the compounding factors that are faced by those from Gypsy Roma Travelling families, those who are living in sheltered accommodation or homeless and those who are refugees fleeing war and persecution.

Our Dental and Maxillofacial services have sought to address these inequalities by working together with our community partners, as well as engaging directly with these communities. Over a number of years, we have worked to establish care pathways, but more importantly we have built a relationship of trust. The trust has resulted from these marginalised communities coming to understand that the health care professionals involved are willing to address their concerns directly. We sought to overcome these barriers by firstly engaging with these communities and looking at the barriers faced by them.

The Trust works with community health workers to identify those in need of dental health advice and treatment and have a specified community liaison worker to access care which has enabled us to provide preventative dental care and advice as part of general health advice for the whole Gypsy, Roma Traveller (GRT) community by tailoring specific rapid access clinics and treatment pathways, including treatment under General Anaesthesia for travelling families who are transient.

We also understood that the GRT communities experience of health care is often negative and that they access care far later than the mainstream population. This naturally leads to poor outcomes and hence a negative view of health care, especially care involving general anaesthesia. We have worked at length to encourage early referral and access and shown that healthcare can be a safe mode of care delivery.

Families fleeing war torn countries who now reside in our communities face high levels of stress and anxiety. Over time we have been able to win each child's trust and have been able to carry out appropriate care.

Families fleeing domestic abuse are often re-housed temporarily in different parts of the country under anonymity. Under these circumstances accessing routine dental care for children can be challenging and fraught with risks. We have worked with

health visitors in order that we have a specific care pathway for these children and their families.

The Trust has an active Inclusion Steering group which is multi-disciplinary and includes membership from across our clinical and non-clinical areas.

In January 2020 we appointed our first Head of Inclusion who works across the Trust to support the implementation of our inclusion action plan which focusses on the needs of patients, communities and our staff and to look for ways in which our services are made even more accessible for a wider range of under-served communities and people with protected characteristics.

At a senior level in 2020/21 our Executive, Non-Executive and Corporate Directors have inclusion objectives included in their annual achievement reviews which is evidence of the Trust leadership embedding inclusion to all aspects of our responsibilities.

The Trust also plays an active part in the work across Surrey Heartlands ICS. Some of the main areas of partnership working includes the reduction in health inequalities work streams in relation to population health, a rapid needs assessment, response working groups both in terms of BAME population health, engagement and the focus on BAME workforce. In June 2020 our Director of Corporate Affairs was asked to lead on the WRES and BAME issues across Surrey Heartlands ICS.

We continue to develop and deliver our SASH One Team Inclusion Strategy, which is overseen by the Inclusion Steering Group (ISG). The strategy sets out our vision to ensure that inclusion is central to everything that we do.

The ISG meets monthly and its purpose is to oversee the on-going development of a fully inclusive environment and culture at SASH. This will provide a framework for inclusion for our staff, our patients and service users, and the wider community.

Our BAME Staff Network has become well embedded in the Trust over the past twelve months with an active membership supporting colleagues across SASH. We continue to use data from our Workforce Race Equality Standard and Workforce Disability Equality Standard submissions to drive change and make SASH the best place to work.

The BAME network have been particularly supportive to staff as emerging evidence showed the impact that COVID was having on different demographics within society. A number of sessions were held with BAME staff to answer their questions about COVID and to highlight how the Trust were responding to the pandemic.

The Trust undertook risk assessments for all staff and used the outcomes of these to provide additional support where required, (eg facilitating remote working, moving staff from clinical duties, etc).

Further sessions and webinars have been held with a focus on risk assessments, lateral flow testing and vaccinations. We used the results of the risk assessments to prioritise staff for COVID vaccinations.

We introduced our SASHAbility passport in October 2021. This provides a formal log for staff to record where adjustments have been made and are required in the workplace. We have also implemented the Sunflower scheme which helps patients and staff with a hidden disability to subtly identify and get the assistance they need. Both schemes have been well received.

We have used LGBT+ history month in February 2021 to launch our new LGBT+ staff network, and expressions of interest in this have been really positive. This is a new network for SASH and we are keen to ensure this has a high impact and supports staff accordingly.

We have a duty to ensure we provide equal access and opportunity to all of our people, whether they are our staff, patients or the public and regardless of whether they have a protected characteristic. We will continue to develop our inclusion strategy based on feedback from staff, service users, and other groups as appropriate to support the delivery of this. We continue to meet our Public Sector Equalities Duties.

We are a Disability Confident Employer which recognises our approach to how we recruit, retain and develop disabled people. We are proud of this achievement and have been invited to speak at regional forums in regard to the work we have done in relation to this. We ensure that where staff develop disabilities during their employment with us, reasonable adjustments are put in place to support them.

Freedom to Speak Up

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

The Guardian reports directly to the chief executive and provides quarterly reports to the Trust Board. The Guardian has a network of ambassadors from diverse roles and backgrounds who work with our clinical divisions and corporate teams.

Guardian for Safer Working

In accordance with the Junior Doctors Contract 2016, the Trust appointed a Guardian for Safe Working Hours. The Guardian's role is to oversee the welfare of doctors in training in relation to their working hours, work intensity, ability to have adequate rest breaks during their working hours, and to ensure that they are able to attend their educational activities unimpeded. While the Guardian is accessible at

any time when needed, the formal channel of communicating the difficulties that arise is through 'exception reporting' which is done electronically.
Once submitted, there is a clear pathway by which the issues raised are attended to by the supervisors of the trainees involved and well laid out escalation options. The Guardian reports directly to the Trust Board but also has access to the Chiefs and executives when needed.

The Guardian is required to provide a formal report to the Trust on a quarterly basis and they attend the public Board meeting to do this.

Black, Asian, minority ethnic (BAME) staff network

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

The BAME network is an inclusive staff network, open to all, including non BAME members who are interested in promoting race equality and inclusion. The SASH BAME staff network was launched in 2017/18 and now has over 200+ active members.

Network objectives

Network objectives are informed by feedback and requests from network members and agreed every January by the BAME network steering group. The current network objectives are:

Policy / Workforce Race Equality Standard and the NHS race agenda

- Support and review Trust policies as required
- Work with the inclusion steering group to understand the impact of WRES data and support action where appropriate
- Be clear about the NHS race agenda and people plan and support or hold the organisation to account in taking this forward

Wellbeing and education

- Continue to support staff wellbeing
- Share learning and educational support and information
- Promote achievements and celebrate successes of our network members
- Provide information about COVID and ongoing other health matters
- Set up the next cohort of conversational English classes for colleagues who do not speak English as a first language
- Continue to listen to and be a voice for BAME colleagues. Remain accessible and flexible and continue to reach and give a voice out to seldom heard groups

Events

- Resume network social events when it is safe to do so
- Continue to promote celebrate and share information about religious festivals and cultural events
- Collaborate with the network members to give a name to the network
- Organise virtual events and webinars with guest speakers
- Participate in induction of new staff, promote and refresh the membership campaign

Working together

- Work closely with the head of inclusion to ensure joined up messaging
- Continue to review and ensure the steering group is representative of all staff – all pay groups and specialties as well as senior members of the team to drive the work forward at a senior level
- Ensure the network has adequate representation/ambassador in Crawley / Horsham

Achievements of the network in 2020/21:

- The network was instrumental in the provision of support and information about COVID-19 to all black, Asian and minority ethnic colleagues, sharing information from other organisations, diverse communities, religious leaders and networks
- The network organised socially distanced peer to peer drop in sessions for information and advice about COVID-19 and the vaccine. As well as face to face and virtual sessions during the day, we also hosted evening drop in sessions
- The network set up and ran a dedicated programme of communications classes for people whose first language is not English. The first cohort of students graduated and have progressed on to the next level of education with a local college. The classes have grown in popularity and the network has now formalised a teaching programme to deliver the classes
- Sky News featured the BAME peer to peer drop in sessions and the accessible visual information created to support colleagues who do not speak English as a first language
- The network has collaborated with The Three Arches restaurant at East Surrey hospital to acknowledge and celebrate special festivals and provide meals from different cultures, starting with a special chicken Thokku and chilled sago pudding to celebrate Sinhala and Tamil New Year
- The network has produced 'Diverse Talks'; a series of virtual talks, that all staff are welcome to join. The talks are an opportunity for our black, Asian, and minority ethnic colleagues to showcase the work they do
- The network worked closely with the communications team to provide accessible printed communications to be given to colleagues who do no regularly access email. As part of this, the network has supported the chief executive and chief nurse at events to listen to and support Estates and Facilities colleagues who do

not regularly access digital communication. As an example of the outcome of these sessions, three I-pads have been introduced to the Estates and Facilities team to enable people to read trust news and check email more easily.

- On 4 June 2020 BAME colleagues invited the organisation to participate to Take the knee in defiance of racism – over 400 members of staff and senior leaders from diverse backgrounds participated
- The network secured £50k of funding from NHS Charities Together to invest in:
    - Reverse mentoring training for colleagues. This is an innovative way to enable individuals in a position of power to gain insights into experiences through the lens of different groups. The programme will train and support frontline BAME staff to mentor their leaders.
    - New and targeted models of engagement with BAME pregnant women and marginalised women. Nationally, black pregnant women are more likely to die as a result of pregnancy than white women. Pregnant women with mixed ethnicity are three times as likely as white women and Asian women twice as likely to die. With the added impact of COVID-19 on the BAME population, our maternity service's COVID recovery strategy includes a focus on reducing health inequalities and this investment will support engagement.
    - Development of enhanced information resources for marginalised communities. During COVID-19 we produced innovative infographics and information for non-English speakers. Our next stage is to take forward similar methods for our local community.
    - We also received money to help us to develop a platform that staff who do not access computers at work can use to meet other colleagues and access trust news. BAME staff told us that making connections with people from similar backgrounds is crucial to their wellbeing. We will develop a new online portal for staff to build networks. Alongside this we will expand our BAME network events to help these connections to flourish either through funding inspiring speakers, hiring venues (should social distancing allow) or purchasing facilitated online events to bring people together. Using less formal tools and methods leads to better communication with and connection between staff.
- The network set up language ambassadors, a team of multilingual colleagues at SASH who are available to support other colleagues who may not speak English as a first language. Our language ambassadors also attend meetings where colleagues feel they may need further information in a common language
- The network has set up a group of people who are available to support colleagues with life admin, writing CV's, filling in applications for jobs or housing
- The chair of the network produces a monthly newsletter to provide a voice and a platform to promote the network and the work of members and inspirational black, Asian and minority ethnic colleagues around the trust.

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

Gillian Francis-Musanu, director of corporate affairs and company secretary and chair of the BAME staff network steering group stepped down as chair in December 2020. Gillian remains a member of the steering group and is the WRES and BAME Executive Sponsor for Surrey Heartlands ICS. Donna Webster, deputy head of communications and patient information manager, previously communications lead for the network became chair in January 2021.

Health and wellbeing

The wellbeing and welfare of our staff during the pandemic has been a key focus over the last 12 months. We have implemented a number of interventions to support them during this time.

These include:

- Critical Stress Incident Management (CISM) support
- Clinical psychological support
- Access to national provided mental health apps
- Access to the Surrey Heartlands resilience hub
- PCR testing
- Lateral flow testing
- COVID vaccinations
- Donations from our community

Staff have told us they require more and better spaces to rest and take breaks. In response to this, we have set up our Inspiring Spaces programme which will use the financial donations we have received from our community to do this.

Occupational health

The Occupational Health team have played a key role in our response to COVID. Our objective has always been to ensure that staff at SASH take a proactive approach towards their health, wellbeing and safety. However given COVID, Occupational Health have been central to supporting staff's wellbeing.

This year they have provided support for the management of COVID absence; run our staff PCR testing centre; been instrumental in the development of our staff vaccination programme; worked as a triage service for many queries about COVID and supported the Bring Back Staff campaign amongst other contributions.

Along with this they have continued to provide business as usual support including for new recruits to the Trust as well as management referrals, delivery of the flu campaign, contact tracing following outbreaks, followed up all work-related staff

absences and incidents to create a safe and supportive environment for our staff; continued to meet relevant national and regional targets around health, safety and well-being.

Friends of East Surrey Hospital

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

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

Like many organisations, The Friends of East Surrey Hospital were impacted by COVID-19. Despite this, they still donated £2,570.00 for additional outdoor seating and granted £520,00 to the Sunshine Nursery.

Our environment

Sustainability at SASH (Care Without Carbon)

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

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

At SASH we use our Sustainable Development Management Plan (SDMP) to deliver these aims, it's called Care Without Carbon. The plan sets out the coordinated actions across seven key areas or, elements. These elements integrate sustainable thinking and planning, into core Trust operations so that sustainability becomes part of business as usual, and key to the way the Trust functions.

Delivering more sustainable healthcare through our seven elements

Our SDMP adopts the Care Without Carbon (CWC) framework for sustainable healthcare, with work streams covering seven different elements highlighted in the figure below:

SASH's seven elements of sustainable healthcare

The Trust's Chief finance officer and director of estates and facilities is our executive lead for sustainability, and each of the seven elements has a senior lead within the Trust. Responsibility for delivery of each element sits with this senior lead, and they are tasked with ensuring that this sustainability programme aligns with strategic goals and priorities within their area at the Trust.

Key highlights from 2020-21

Highlights from our sustainability programme this year include:

- Planting 150 trees to improve wellbeing and break spaces for staff, patients and visitors. When fully grown these trees will absorb over 3 tonnes of CO_2 per year.
- Installing six new electric charging points for staff use, bringing the total at East Surrey Hospital to ten. Four of our charging points are available for patient and visitor use.
- Continuing into our third year of our staff engagement programme Dare to

Care, strengthening the communications set out in year one and growing our reach by attending Trust wide events as well as refreshing our communications materials

COVID-19 and sustainability

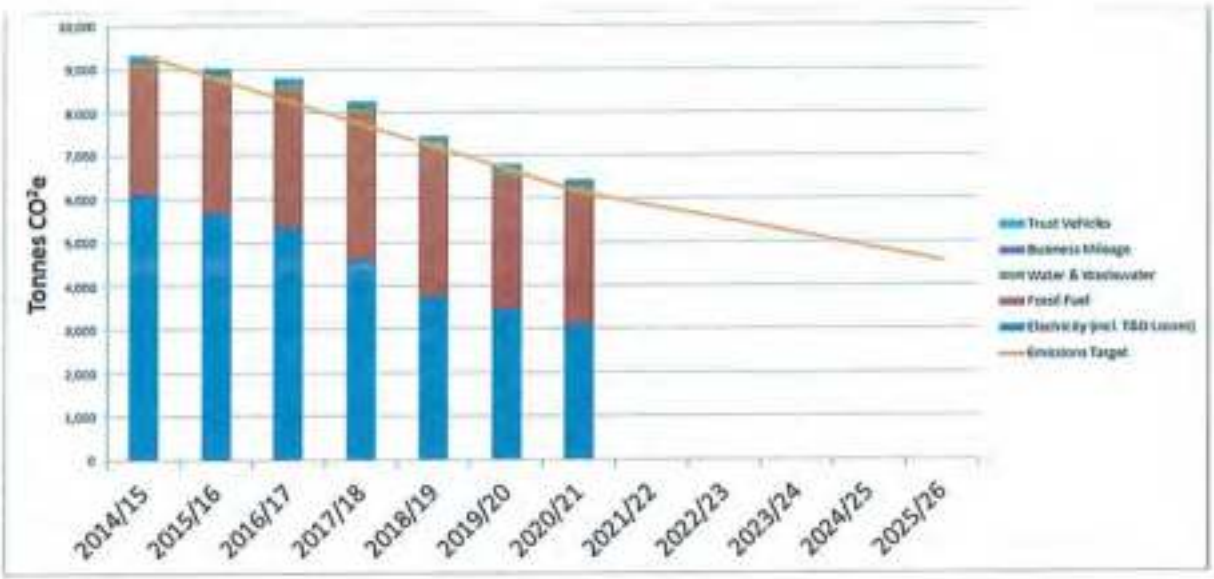
COVID-19 had an undeniably profound impact on the NHS in 2020/21. From a sustainability perspective the pandemic significantly increased the purchase, use and disposal of healthcare items including a marked increase in PPE and infectious waste. Over the past year spotlight has been firmly placed on staff wellbeing and this was reflected in CWC's staff engagement programme, Dare to Care. During 2020/21 more staff drove to work and travel by public transport reduced, there was also limited visitors to our main site.

Environmental impact

Our carbon footprint

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also transport Trust staff, patients and goods, and purchase a large range of equipment and services. All of these activities generate carbon dioxide (CO_2) emissions, which are linked to climate change, and can be collectively summarised as our carbon footprint.

Since our baseline year of 2014-15 we have reduced our absolute carbon footprint by 2,983 tonnes CO_2e[1] (31%). We are making a steady reduction in our emissions, year on year and we are planning for energy conservation measures over the coming years to increase our emissions. Our progress towards our targets is detailed in the graph below.



SASH carbon emissions to 2020-21

[iii] CO_2e is the standard unit for measuring carbon footprints. It reflects the impact of all six greenhouse gases that cause global warming including carbon dioxide and methane. This is important as some of the gases have a greater warming effect than carbon dioxide.

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

Progress against our seven elements

Leadership: leading the way for sustainable healthcare policy and practice.

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

Our progress: This is the final year of our strategy in its current iteration; in 2021/22 we will publish our new strategy or, Green Plan which will define our approach to sustainability until 2025 and will set out our longer term direction. In our next strategy we will be aiming for a 51% carbon reduction by 2025 and net zero carbon by 2040 in line with the NHS Long Term Plan and A Net Zero National Health Service.

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

2020 target: 34% reduction on CO_2e from our buildings.

Our progress: The energy we use to power, heat and cool our buildings is the most significant contributor to our Trust's carbon footprint. Absolute CO_2e emissions from building related energy consumption have fallen considerably between 2014/15 and 2020/21 but there is still a substantial amount of work required in order to meet our net zero carbon target by 2040. Key highlights and projects for the year ahead include:

- Continuing to review funding options for energy infrastructure projects on site at East Surrey Hospital including low carbon heating upgrades and renewable power generation.
- a key project for 2020-21 will be to update our carbon targets within our refreshed Green Plan to 2025 in line with the NHS Long Term Plan commitment of a 51% reduction.

The Trust moved onto a renewable electricity contract on the 1 April 2018 and we have continued this since. We are currently investigating a better way to reflect this

in our reporting of emissions associated with electricity. As a result of this procurement decision emissions from our green electricity consumption when using contract-specific emissions factors were 0 tonnes CO_2e, whilst when applying the grid factor they were 2,854 tonnes of CO_2e.

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

2020 target: 34% reduction in all measurable travel CO_2e.

Our progress: The NHS accounts for one in five vehicles on the road and travel accounts for 14 percent of the NHS carbon footprint which is a significant environmental impact. COVID-19 had impacted car travel for the Trust with more staff choosing to drive their own vehicles to work rather than take public transport, conversely there has been a reduction in the amount of visitors and associated vehicle traffic on site. In particular:

- During 2020/21, due to the pandemic we were able to close a car park due to reduced visitor numbers for six months to provide additional staff parking and allow for essential works.
- We continued to partner with Living Streets on their 'Walking Works' programme to build on engagement around active travel through walking.
- We promoted active travel through our 'one less car journey per week' Dare. Through this, staff are asked to either car share or, reduce their solo car journey by cycling or walking instead.

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

2020 target: engage suppliers in reducing impact on the environment.

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

- Continuing with our commitment to removing single use plastics from catering following the Trust's sign up to the NHS Plastics Pledge.
- We have taken steps to carbon footprint our supply chain and in 2021/22 will set about implementing projects to reduce our carbon footprint in this area.
- We are continuing to send our domestic waste to the energy from waste facility as opposed to landfill. This generates electricity to power homes and any residual bottom ash generated is sent to be used as aggregate on the roads.

- We started work to quantify the environmental impact of our anesthetic gas use. Next year we will look to work with clinical departments to discuss making reductions of the most harmful anesthetic gas, Desflourane.

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

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

Our progress: Dare to Care launched in November 2018 with a selection of 11 dares (a dare is a small pledge to do something differently) focused on reducing our impact on the environment, and improving wellbeing, now in its third year. A key aspect of our engagement methodology is to link health with sustainable behaviours. To date, 885 dares have been taken by 147 staff. The top three Dares taken by staff are; 'Take a walk', 'Switch it off' and 'Drink every drop'.

- We had planned to launch a CWC Envoy, or champions programme in 2020/21 but this has been postponed to 2021/22 due to the pandemic, along with a planned refresh of the pledges available through Dare to Care.
- We provided the Kaizen Team with a workshop on Care Without Carbon early in 2020 to support the programme in building sustainability into considerations for outcomes from future Kaizen projects. This will support a culture of sustainable thinking at a more clinical level.

Wellbeing: creating a better working life for our people.

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

Our progress: Through the Dare to Care engagement programme the Take a Walk pledge continues to be the most popular of all the pledges.

- In 2020/21 we had planned to introduce a Dare to Care stand at all Trust induction events to talk to staff about the links between healthy and sustainable behaviours. Unfortunately, this was then postponed due to the pandemic.
- In early 2020/21 the 'Step Up Challenge' ran for a second year, inviting staff to walk a virtual route over 12 weeks which supports 10,000 steps per day. With the advent of the pandemic, participation was very low and we hope the introduction of new routes for the Challenge in 2021/22 will inspire higher participation rates.
- In March 2021 we were able to secure 150 trees for the Trust through the Centre for Sustainable Healthcare, to create green spaces for wellbeing on site.

Future: supporting a strong local health economy to serve our economy now and in the future.

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

Our progress: We are planning to working in partnership with other trusts in our region to develop joint sustainability projects and this will form part of our new Green Plan in 2021/22. We will kick start this work by looking at our own climate change risk assessment.

- To support our work on climate change adaptation and staff wellbeing we planted 150 trees on our East Surrey Hospital site. These trees will primarily be used to form improved breakout and wellbeing spaces for staff, patients and visitors.
- For 2021/21 our priority will be to further develop our work around climate change adaptation, in particular through Trust specific climate change risk assessment to understand the impact climate change will have on our buildings and delivery of our services. This is alongside refreshing our Sustainable Development Management Plan or, Green Plan and updating our targets to take us to 2025/26.

Signed: 

Michael Wilson CBE, chief executive

Date: 14 JUNE 2021

Accountability report

Corporate governance report

Directors' report

Our Board of directors, board and sub committees

We remain committed to ensuring that our governance systems and arrangements are cohesive and ensure that our approach is co-ordinated and combined.

Throughout the year we considered and adapted our corporate governance systems to ensure our Board and its subcommittees where focussed on the safe management of the COVID-19 pandemic and the prudent use of public resources to support the management of the pandemic across the Local health and social care system.

Our directors' report follows:

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

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

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

Membership of the Board of directors

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

Other senior employees attend the Board as the Board of Directors consider appropriate. The Board of Directors provides assurance and leadership of the Trust towards the achievement of corporate objectives and oversight of the framework of

sound internal controls, risk management and governance in place to support their achievement.

The Board of Directors is responsible for:

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

Board members: statement of director responsibilities and declarations of interest

Non-executive directors (NEDs): Non-executive directors have a wide variety of experience in the voluntary, public and private sectors. They are all part-time. Their declarations of interest for 2020/21 are:

Richard Shaw, chair

- None to declare

Paul Biddle, chair of audit and assurance committee

- Non-executive director W&J Linney Ltd
- Trustee of King Edward VII Hospital in London

Pauline Lambert, deputy chair and senior independent non-executive director

- Part-time Clinical Safeguarding and Mental Capacity Act Lead - Queen Victoria Hospital NHS Foundation Trust

Caroline Warner, chair of safety and quality committee

- Chair, Consumer Challenge Group at Affinity Water
- Lay Member and Interim Lay Convenor for Frimley Commissioning Collaborative

David Sadler, chair of finance and workforce committee

- Owner/director – David Sadler Advisory Ltd
- Director Coach Associates Ltd
- Lead Non-Executive Director on the ICP element of work stream 8 under the ICS Recovery Programme

Paula Swann chair of charitable funds committee

- Advisor – Citizens Advice

Sutton

Yasmin Khan, , deputy senior independent non-executive director

- Consultant Paediatrician in Neurodisability, Ingfield Manor School, Billingshurst, West Sussex
- Medical Lead & Consultant Paediatrician in Neurodisability, Young Epilepsy, St Piers Lane, Lingfield
- Trustee Martlets Hospice, Hove
- Consultant Paediatrician in Neurodisability – Sussex Community Foundation NHS Trust – on the staff bank

Executive directors

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

Michael Wilson CBE, chief executive

- Special Advisor for the Care Quality Commission (CQC)
- Honorary President of the East Surrey Branch of the NHS Retirement Fellowship
- Co-Chair South East Coast Regional Talent Board & representative at Regional Talent Board Meetings
- Chair of the A&E Delivery Board for the SASH System
- Member of the National Trust Guiding Board – Virginia Mason Institute Programme
- Member of West Sussex County Council Health & Wellbeing Board
- Member of the Surrey County Council Health and Wellbeing Board

Paul Simpson, chief finance officer and deputy chief executive

- Trustee of Gamble Aware & Chair of Audit Committee
- Member of Surrey Heartlands ICS Recovery Board

Dr Ed Cetti, medical director

- One weekly private patient outpatient clinic at Spire Gatwick Park Hospital

Jane Dickson, chief nurse

- Director of private company that is building a holiday home for renting purposes
- Director of Mull Moments Ltd (50% share holder)

Angela Stevenson, chief operating officer

- Shareholder in Kate Grimes Ltd, Executive Life Coaching

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

- Home Office Authorised Person (Marriage Registrar): London Borough of Hounslow and City of Westminster
- Member of Hillingdon Hospital NHS Foundation Trust

- Judge on the panel of the Health Service Journal Partnership Awards 2020
- Assessor Panel Member for Aspire Together – South East Regional Talent Board
- Executive Sponsor for BAME & WRES, Surrey Heartlands ICS
- Chair SASH BAME Staff Network (until Dec 2020)

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

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

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

- Member of Surrey and Borders NHS Foundation Trust

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

Adaptations to ensure appropriate governance and management of the Trust through the pandemic

The Board has considered and adapted its ways of working to ensure appropriate governance and oversight was maintained throughout the pandemic. This included:

- Focussed review of agenda timings and meeting agendas to allow the Executive team to focus on operational matters during peaks of COVID-19 activity
- Review of standard reports and metrics to ensure focus on appropriate matters of safety and effectiveness of care
- Attention to matters of patient, family and careers experience particularly on communication systems to support wellbeing
- Focus on staff welfare and assurances that relevant actions were being taken by the Trust
- Establishment of additional powers and delegated authority to allow urgent decisions to be made between meetings by the Trust Chair and Chief Executive
- Focussed agendas of the Trust Safety and Quality Committee to provide wide assurance on all matters of quality of care relating to the pandemic, other emergency activity such as stroke and urgent electivity activity such as the management of elective cancer activity.

Key committees

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

The terms of reference of each committee sets out the remit of responsibility delegated by the Board of directors and sets out the information requirements of the committee, how it should interact with the information it receives and use this to reach a conclusion about assurance. Where assurance cannot be robustly established, the chair of the committee reports this to the Board of directors. These are reviewed annually and collated into the Trust's Rules of Procedure.

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

Core Board sub-committee structure
The key functions of the Board sub-committees are:

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

During the year the committee focussed on the controls that ensured COVID-19 monies were spent appropriately.

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

Nomination and remuneration committee: To appoint and, if necessary, dismiss executive directors, establish and monitor the level and structure of the total reward for executive directors, ensuring transparency, fairness, consistency and succession planning. The committee also ensures the requirements of the Fit and Proper Persons Regulations are fully implemented and reviewed.

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

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

During the year the committee continued to meet, with a focussed agenda and invited all Board members and external partners to seek and gain assurance on the management of the pandemic from the Executive Team and Clinical Chiefs of Service.

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

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

The committee focussed significantly on the use of Charitable funds to support the health and wellbeing of both Trust staff, patients and their families throughout the pandemic and has an overview of the Trust's fundraising activities

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

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

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

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

Significant risk register
The significant risk register details all risks on the Trust risk register system that are recorded as significant and link to the Board Assurance Framework (BAF). The executive committee oversees (through the head of corporate governance) the maintenance and review of the BAF. It is then discussed and challenged at the Trust

Board prior to its acceptance. The BAF and significant risk register are presented at public Board meetings. Throughout the year the Executive Team developed and provided the Board with risk registers that focussed specifically on the management of pandemic associated risks.

Statement of Directors' Responsibilities in respect of the accounts

Each director confirms that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

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

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

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

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

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

By order of the Board

Michael Wilson, Chief executive

Paul Simpson, Chief finance officer

Directors' membership of Board sub-committees

Audit and assurance committee	Nomination and remuneration committee	Safety and quality committee	Finance and workforce committee	Charitable funds committee
Chair Paul Biddle	**Chair** Richard Shaw	**Chair** Caroline Warner	**Chair** David Sadler	**Chair** Paula Swann
Members* David Sadler Caroline Warner In attendance Chief finance officer Director of corporate affairs Other members of the executive and non-executive team are invited to attend as and when required	**Members*** All NEDs In attendance Chief executive Director of people and organisational development	**Members*** Pauline Lambert Yasmin Khan Chief nurse Medical director Chief operating officer Chief finance officer Clinical chiefs	**Members*** Paul Biddle David Sadler Paula Swann Chief finance officer Director of people and organisational development Director of information and facilities Director of corporate affairs Chief nurse Chief operating officer Associate medical director	**Members*** Caroline Warner Yasmin Khan Chief finance officer Deputy chief nurse Director of corporate affairs Director of information and facilities

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

Annual Governance Statement 2020-21

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.
I report to the Chair of the Trust and ensure appropriate systems exist to support the work of the Trust and the Board. I manage and lead the Executive Team who have clear accountabilities and annual objectives which are drawn from the Trust's strategy.

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Surrey and Sussex Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Surrey and Sussex Healthcare NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

2.1 The management of the COVID-19 pandemic and the Trust's response

The Trust's governance has responded effectively and appropriately to the onset of the COVID-19 pandemic.

The Trust enacted its business continuity plans, followed national guidance and focussed on providing urgent and safe health care. Re-shaping the services it provided and managed the emergency demand, whilst tackling significant workforce reductions and initial issues of national PPE availability.

The Trust reviewed its governance forums to ensure only business critical meetings were held, meetings where shortened and held virtually where appropriate. Board meetings and its sub-committees moved to virtual meeting formats and reviewed agendas to ensure an appropriate focus on operational and safety matters whilst also focussing on long term strategic matters and planned recovery from the pandemic.

The Executive Team meetings focussed on business critical matters and the Executive Committee for Quality and Risk focussed on safety matters, mortality and the management of risk.

The Trust Board also enacted Emergency Powers reserved to the Board as contained in the Standing Financial Instructions (SFIs and Standing Orders (SOs)).

This response included.

- The Board resolved that meetings would be held virtually with the agenda restricted to critical business only; monthly sub-committees would also restrict the agenda to critical business only and be limited to a maximum of one hour duration.
- Between March 2020 and November 2020 meetings in public were not possible due to national social distancing guidance. However all Public Board agendas and papers were available on our website.
- The emergency powers in the SFIs and SOs were amended to provide for emergency decisions to be taken by the Chair and Chief Executive only where it was not practical to consult with the full Board. Any use of these Powers was reported to the next Trust Board meeting for ratification.
- Commencement of Gold command meetings that I chaired attended by the Chief Operating Officer / Accountable Officer for Emergency Preparedness, Resilience and Response, Chief Nurse and Medical Director who were responsible for setting the strategy in response to COVID-19 at SASH.
- During peaks of activity, strategic team meetings with divisional Chiefs were held five times a week; planning the strategy set out by gold command (including weekends).
- Tactical team: Single point of contact for key areas such as Procurement/PPE, Infection Control, Workforce, Estates and Facilities, Pharmacy, Communications and Welfare; all meeting every day to review operational actions and updates.
- Establishment of a Clinical Hub to manage the redeployment of staff to support the response.
- Sourcing of all PPE and necessary additional resources by procurement.
- Remote working from home for some staff in line with appropriate national guidance.

- Established a focussed review for matters of clinical quality and safety which ensured that the Executive Team, Board and Commissioners remained sighted on all relevant matters of quality of care. The Safety and Quality Committee of the Board met regularly throughout the pandemic focussing on gaining assurance of delivery of urgent care and emergency services provision. This was attended by senior quality leads from the Integrated Care System. During this period supported by effective communication and sharing of assurances of quality of care the Trust's Commissioners suspended their contractual quality assurance committees as there were no significant concerns in this period.

I am not aware of any issues caused by a failing in the Trust's internal control systems that represent a significant control issue, relating to the management of COVID-19 pandemic.

3.1 Capacity to handle risk

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

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

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

- The "Rules of Procedure" approved by the Board in January 2011 (updated January 2021) clarifying roles of Board members and defining the role and structure of Board sub-committees;
- A clear accountability framework for managing risk from the Accountable Officer downwards as set out in the Risk Management Policy;
- The structure of permanent committees, including Board sub committees (see Section 2);
- The Board Assurance Framework and the Significant Risk Register (all significant risks are recorded on the Trust risk register)

- The Trust's risk management process takes into consideration the need to manage all types of risk as relevant to key stakeholders and provides one to one competent support and regular training events.
- The significant risk register is taken from the Trust's risk register and is reviewed by the Executive Committee and presented at the Board meeting quarterly, these papers are made publically available on the Trust website. During the financial year the Private Board received regular risk updates on the Trust's management of the pandemic, focussing on the risks associated with the management of the pandemic. Board risk management activities during the peaks of the pandemic were focussed appropriately on the management of the emergency pathways and returned to a normal review during periods of reduced pressure.
- The Trust's Performance Management Framework;
- Compliance with Care Quality Commission standards and registration, Information Governance rules, health and safety requirements, and those of other regulatory bodies;
- The work of Divisional and specialty governance meetings, led by divisional triumvirate (Medical Chief, Chief Nurse and Associate Director;
- The system of local risk coordinators and Divisional Governance managers;

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

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

The Board actively encourages well-managed and defined risk management, acknowledging that service development, innovation and improvements in quality require risk taking. This position is based on the expectation that there is a demonstrated capability to anticipate and manage the associated risks. This stance is defined by the Board's risk appetite which is reviewed annually and included in reports presented to the Board. During the year the Trust Board included Inclusion and Diversity in its risk appetite.

3.2 Specific strategic and operational risks

The Board of Directors identify and record strategic risk in the Board Assurance Framework (BAF). Clinical risks and non-clinical operational risks are reviewed by

the Executive Committee, the Executive Committee for Quality and Risk and the Board.

The BAF recorded identified one red rated significant risk to the Trust meeting its strategic objectives at the end of the financial year.

Risk description	Current rating	Target risk score
4.1 The reduction of elective work in outpatients, surgery, cancer and diagnostics due to COVID-19 has meant that there is a significant rise in the number of patients waiting an excessively long time for their procedure. The situation is likely to get worse because referrals are increasing. These issues are very likely to adversely impact delivery of elective care, quality outcomes, staff satisfaction, income and expenditure.	S4 x L4 = 16	S3 x L2 = 6

The BAF is a public document available on the Trust website; it details the strategic risks to the Trust's objectives. Each BAF risk includes details of the controls in place, gaps in controls and mitigating actions identified by the Executive Lead to reduce the severity or likelihood of the risk impacting on delivery of the Trust's strategic objectives. BAF risks are discussed in detail at the Public Board, the Audit and Assurance Committee and the Executive Committee. Due to operational imperatives the BAF was reviewed three times during the year, rather than the planned four reviews.

The Trust records non-strategic risk on its risk register. These risks are operational and can be particularly short-term in nature. These are discussed and monitored in detail by the Executive Committee and its sub-committees and reported to Public and Private Board and the Audit and Assurance Committee.

4. Quality governance

The Trust uses an internally developed system to monitor all aspects of performance and quality. This takes the form of a regular report based on the Department of Health's and NHS England/Improvement performance indicators, and the monthly finance report as part of the Integrated Performance Report.

The Trust has developed a series of performance management systems that monitor individual elements of performance and trigger actions. For example there is a set of reports available to the Board on a regular basis which monitor performance in all key business areas of the organisation. Performance reports demonstrate that action is taken, both at the Executive Committee (and its five sub committees) and at

operational meetings to address variances from objectives, standards and targets. Where variance is identified, action plans are established to address them and reviews of action plans undertaken to ensure that the desired results are achieved. These are monitored by division specific performance meetings.

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

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

Divisional teams have a simple process for escalating issues from Divisional governance thorough the relevant sub-committees of the Executive Committee for Quality and Risk and up to the SQC and public Trust Board. This is supported by the Trust's incident reporting system and when necessary the whistleblowing policy and the role of the Trust's Freedom to Speak Up Guardian (FSUG).

I encourage all staff to raise concerns through the processes described above and welcome any member of staff to discuss significant issues with me, one of my Executive Colleagues or the FSUG.

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

4.1 Organisational learning

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

Learning is supported by the consistent application of after action review and root cause analysis of problems and incidents. The avoidance of blaming individuals for system failures is a cornerstone of this reporting culture and is described in various Trust policies, including the Organisation-wide Policy for the Management, Reporting and Investigation of Incidents (including Serious Incidents - SIs). The Trust has implemented systems to ensure compliance with the Duty of Candour requirements.

The Trust has a range of problem resolution policies and procedures, including whistle blowing, respect, capability, disciplinary and grievance, which are designed to identify and remedy problems at an early stage. This is supported by a number of individual mechanisms to encourage individuals to raise concerns about performance in ways which will not threaten their security or livelihood, e.g. appraisal, alcohol use/abuse policies, professional counselling and occupational health services. As previously noted the Trust has also appointed a FSUG who reports to the Trust Board on a quarterly basis and who can discuss any matters with me and is supported by a number of Freedom to Speak Up Ambassadors.

The Trust has in place a Counter Fraud Contractor whose services are embedded within the Trust. More details are provided below.

4.2 Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. These detail the Trust's performance against a series of quality indicators and the Trust's plans to continually improve the quality of its services.

The Quality Account is developed internally and shared with our local health partners before publication and submission to NHS England/Improvement. The Executive Team provides me with assurance and regular updates on the drafting of the account. In line with national guidance, the 2020-21 Quality Accounts audit will not be carried out. However, the Trust will seek review and feedback from partners in the wider health and social care system which will mirror the review of External Audit.

4.3 Data quality, elective waiting time and Cancer Access standards

The Trust has a number of appropriate systems to ensure data quality, led by its data quality team. The Trust's Divisional and Corporate governance meetings review data regularly and challenge any areas which may be linked to Data Quality. All Board level data is reviewed and signed off by an Executive Director or their Deputy. The Trust has carried out significant programs of work to ensure accuracy of data, particularly in RTT and cancer elective standards, which has significant benefits for a range of data streams.
Assurance of elective waiting time data is provided though the Trust's overarching Data Quality framework which, in relation to elective waiting times, includes

- Training of front end system users in both system usage and Elective waiting time rules
- Well established data quality team in relation to RTT which has remained in place throughout COVID.
- Elective waiting times included in the Internal Audit programme

5. Well Led

The Trust is currently rated as 'Outstanding' overall by the CQC, this includes 'Outstanding' ratings for 'Well Led' and the 'Use of Resources' domain.
The inspection was carried out on 16 to 17 October 2018 and the report was published in January 2019. The Trust was also subject to an inspection of both the 'Well Led' domain on 13 to 14 November 2018 as well as 'Use of Resources' an assessment carried out by NHS Improvement. Both of these inspections culminated in the Trust being rated as 'outstanding'. (See the CQC section of the annual report).

PwC conducted a Well-Led Framework Governance Review at SASH in July and August of 2018. The report confirms that SASH is a Well-Led organisation. The assessment and RAG rating by PwC for each of the Key Lines of Enquiry (KLOE) mirrors that of the Trust's' self-assessment of the Well-Led Framework; (seven green and one amber/green). Patient and Public Participation was rated as amber/green and has been a focus of increased attention during the financial year; although face to face activities have been limited the Trust has supported the development of a number of system wide patient groups particularly local disability forums. The Trust is seeking to increase patient and public representation at Trust governance forums in line with the National Patient Safety Strategy.

Both the CQC inspection report and the PwC Well Led Framework report focus on opportunities to further develop our current governance processes. The Trust has developed action plans to implement these improvements and continues to review opportunities to improve the governance of the Trust.

The Trust was included in part of national programme of CQC inspections in March 2021, focussing on Infection Control. The report has been published and identifies areas of outstanding practice and good overall compliance. No immediate concerns were identified or reported to the Trust; however the report does include areas for improvement; focussing on refurbishment and storage.

5.1 NHS provider licence

Surrey and Sussex Healthcare NHS Trust is able to confirm full compliance with all relevant aspects of the NHS provider licence as they relate to non- Foundation NHS Trusts. The Board has reviewed the conditions of the licence including condition 4 and is able to confirm compliance with the following:

- there are effective and robust governance structures in place;
- there are clear responsibilities of directors and subcommittees;
- there are clear and robust reporting lines and accountabilities between the

Board, its subcommittees and the Executive Team;

- the Trust submits timely and accurate information to assess risks to ensure compliance with the conditions of the licence; and

- the Board has consistent and systematic oversight the of the Trust's performance through its accountability framework.

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

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

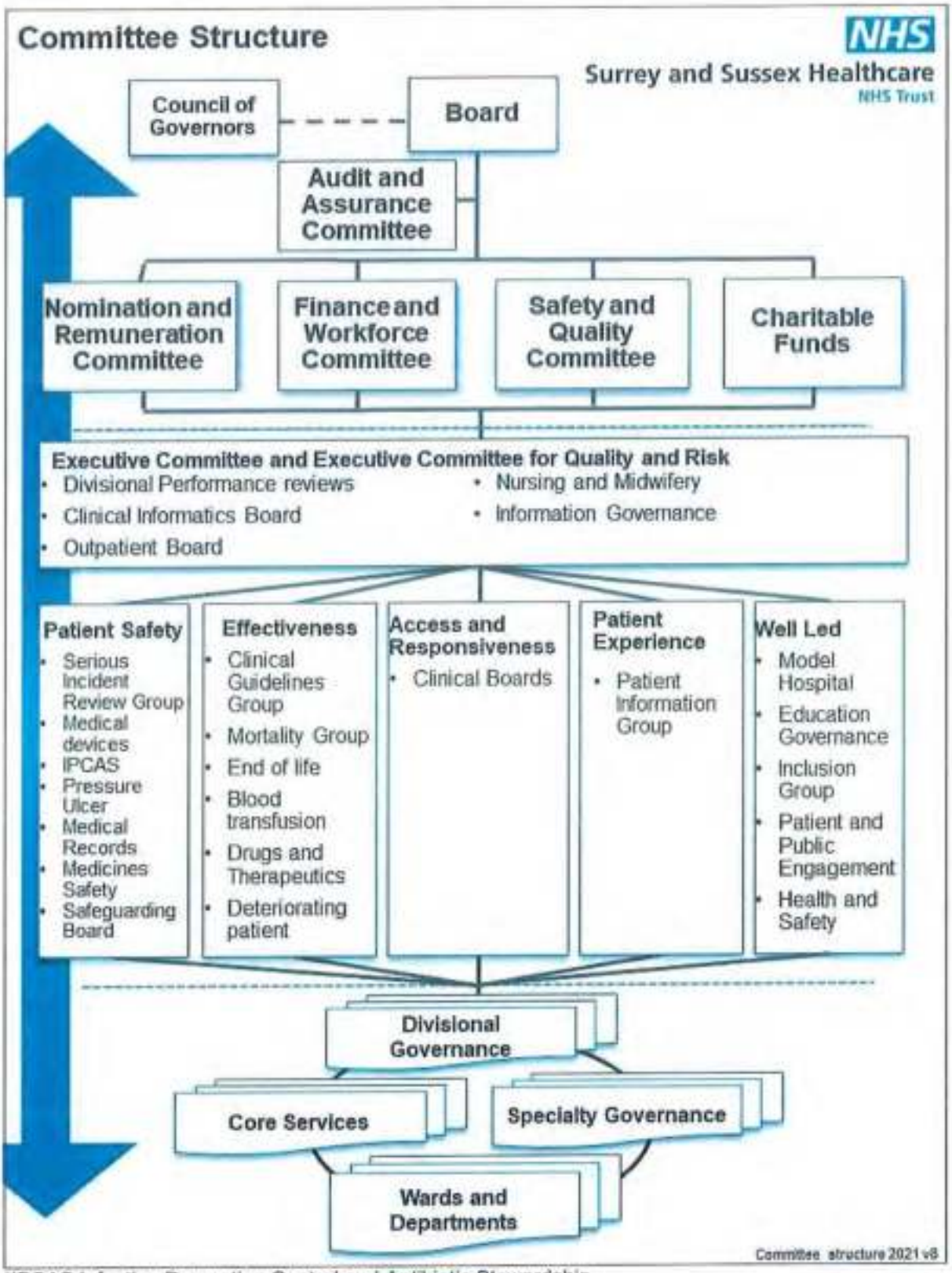
I have aligned and delegated accountability (see Section 1 above) and decision making authorities to the line management structures in place that deliver the day to day business. This alignment provides all staff and the Board of Directors with a simple and well understood way of:

1. ward/operational reporting to the Board any relevant issues

2. the Board disseminating its strategy and objectives to the wards and operational services

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

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



*IPCAS Infection Prevention Control and Antibiotic Stewardship

The Audit and Assurance Committee have scrutinised the Board Assurance Framework and added value to the description of strategic risks.

The Audit and Assurance Committee receive regular audit reports conducted by Internal Audit, the majority of which provide reasonable or substantial assurance. During the year an audit of the Trust's Fire Safety management provided a partial assurance opinion, identifying elements of supporting governance that could be improved to increase oversight and assurance at corporate level. This has been reviewed by members of the Executive Team and actions developed which Internal Audit is monitoring until implemented.

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

The Trust ended 2020/21 with a £47k surplus [subject to audit] after allowable technical items (including revaluation impairments and donated assets adjustments) were taken into account. Model Hospital data describes the Trust as the 5th lowest cost acute trust as measured by the cost per weighted activity unit (£3,440 per WAU) nationally. A detailed value for money assessment has been submitted to the auditors as part of their audit of the financial accounts.

Throughout 2020/21 all NHS trusts have been working to a COVID finance regime that is very different from the finance regime operated in 2019/20. The technically adjusted break-even position achieved meets the Trust's financial plan for the year and the expectations of NHS England/ Improvement (NHSE/I) within that finance regime.

The Trust has an embedded budgeting and cost improvement (waste reduction) process, an embedded financial reporting process and performance management structure. The latter consists of monthly meetings with Divisions, monthly reporting to Executive Committee, Finance and Workforce Committee and Board. Standing Financial Instructions and financial procedures are in place and are updated annually. During the COVID year the Trust maintained most of its performance management structure (some divisional meetings were stood down during the COVID surges) and provided an internal COVID finance process that augmented the standing financial instructions. Internal audit reviewed those internal processes in September 2020 and provided 'substantial assurance' in respect of COVID financial management.

The Audit and Assurance Committee reviews the management opinion on internal controls systems for resource management (and did so during 2020-21, stating assurance) and audits from internal audit and external audit. All internal audit reports have provided good assurance in relation to finance areas during the year. The 2020-21 external audit report will be received after this AGS is written, but in the 2019-20 audit, auditors gave the Trust an unqualified value for money. That stated that auditors were satisfied that the Trust had put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources.

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

5.3 Efficiency and effectiveness

The Trust has embedded a number of key processes and change programmes to deliver continuous improvement, greater efficiency and effectiveness. The COVID year has clearly impacted on the operation of these processes, but in many respects they have helped the Trust to manage the service flexibility it needed to achieve to manage the COVID surges, and the prompt stand-up of elective work after the first and second COVID surges (which the Trust managed strongly). These key processes include the examples below:

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

  By focussing on the elimination of waste our SASH+ improvement methodology has helped us to become more efficient and reduce costs but more importantly it has engendered a culture of continuous improvement where staff are taking responsibility to improve their service on a daily basis. Another output of this is likely to be the strong performance in the staff survey and SASH+ is an enabler to delivering our waste reduction programme and has successfully identified opportunities for additional income, reduction in costs and improved efficiency

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

Hospital Group reports directly to the Executive Team and an overview of activities and successes are reported to the Finance and Workforce Committee.

- Elective productivity programme: the Chief Operating Officer manages a formal elective productivity programme based around Theatres, outpatients, and endoscopy that is reported to the Finance and Workforce Committee.

- Committee structure: the internal structure of monthly committees that supports the Executive Committee for Quality and Risk (Effectiveness, Patient Safety, Patient Experience, Access and Responsiveness and Workforce) provides the governance around each of these areas and incorporates efficiency and effectiveness within their coverage.

5.4 Workforce

The Trust has a Board approved workforce strategy, (approved in July 2018), which details our plans to ensure that the right staff, with the rights skills are in the right place at the right time. The strategy is based on six key themes which ensures short, medium and long-term planning is undertaken to deliver safe, sustainable and effective staffing levels and provide the highest quality of care to our patients.

Progress against the plan is reported to the Board monthly through the Board Assurance Framework and through regular reports from the Executive Team to the Finance & Workforce Committee (which is a Board sub-committee). Our workforce plans are evidenced based, benchmarked against the Model Hospital, directly linked to other Trust strategies and are supported by relevant education and training activities as required, including the development of new roles. We have implemented an effective recruitment and retention plan and have initiated plans to reduce agency spend, whilst growing our own bank. We use our SASH+ methodology to support lean working and transformation and we have business continuity plans in place to support unplanned workforce challenges.

The Trust is involved in national and local initiatives to support and develop our workforce and we take assurance from regular feedback from staff and other internal and external stakeholders. We aspire to be the local employer of choice and the best place to work. We have undertaken significant consultation with our staff during the past financial year and we are developing action plans to address key issues that have been raised. As part of our CQC inspection, as well as the overall Trust being rated as Outstanding, we also received an Outstanding rating for our Use of Resources.

In light of the COVID-19 pandemic, the Trust has reviewed its health, well-being and welfare offer to staff to ensue this is appropriate and meets staff needs. Health and

well-being has been highlighted a key priority in the 2021/22 NHS Operating Plan and the NHS People Plan/People Promise.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. (See the equality, diversity, human rights section of the annual report). Inclusion will be a particular focus for the Trust given the impact of COVID-19 on different protected characteristics and the results for SASH of the 2020 National Staff Survey.

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.

5.5 Conflicts of Interest

The Trust has published on its website a register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) this is reviewed annually, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

5.6 Sustainability

The Trust has undertaken risk assessments and has a Sustainable Development Management Plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust is working in partnership with Sussex Community NHS Foundation Trust to deliver Care Without Carbon, our vision for sustainable healthcare which sets out actions to drive improvements and mitigate the risks associated with climate change and is in line with our Estates Strategy. See the sustainability section of the Trust 2020/21 Annual Report for greater detail.

5.7 Information governance

The Data Security and Protection Toolkit (DSPT) is an online tool that enables the Trust to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care, notably the 10 data security standards set by the National Data Guardian.

To provide assurance that the Trust is practising good data security and that personal information is handled correctly the Trust is required to carry out self-assessments of their compliance against the assertions and evidence contained within the DSPT.

While some elements are mandatory, the DSPT also provides a mechanism for organisations to continually monitor their own performance and so be able to evidence improvement over time against recommended elements.

Due to the COVID-19 pandemic the DSPT for 2020/21 was launched in December 2020 and the final submission moved to 30 June 2021. Surrey and Sussex Healthcare NHST Trust is in the progress of uploading evidence to the DSPT and will be submitting on 30 June 2021.

The Trust overall rating for the DSPT will either be published as standards met or Standards not met.

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

All data security risks are added to the Trust risk register and reported in line with the Trust Risk Management Policy. The Trust has not identified any data security Serious Incidents during the financial year.

There are processes in place for incident reporting and investigation of serious incidents. During 2020-21 all reported data security incidents were of minor significance.

During 2019/20 NHS Digital extended the DSPT final submission to September 2020 due to the Covid-19 pandemic however the trust was in a position to submit the toolkit on 28 March 2020 and published 'Standards Met'.

6. Review of effectiveness

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

My review is informed in a number of ways.

- As described above I take significant external assurance from both the result of CQC inspection of Trust and external Well Led review during 2018-19, as the last formal external reviews of the Trust and its governance.
- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.
- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Internal Audit reports have been targeted at a broad range of areas to identify issues and the Head of Internal Audit Opinion states:
  'The organisation has an adequate and effective framework for risk management, governance and internal control.
  However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'
- External auditors provide me with assurances through their opinion on the financial statements and their value for money conclusion.
- Other external organisations, including the NHS England /Improvement, the Care Quality Commission, MHRA, other agencies of the Department of Health and our commissioners have provided me with reports about controls, compliance with standards, financial management and performance in delivering targets.
- The Trust's Audit and Assurance Committee (AAC) is constituted to provide the Board of Directors with an independent and objective review of its systems of internal control, financial information and compliance with laws, guidance and regulations governing the NHS. As such throughout the financial year the AAC has gained assurance and driven improvements in controls from reviews of the Trust's internal control systems.
- The AAC has gained assurance from External Audit relating to the final audited accounts and value for money and has received independent assurance from internal audit on a series of controls both corporate and clinical. The Committee continues to receive and consider internal and independent assurances and has adopted the 'three lines of defence' model to provide context and depth of assurance.

6.1 Significant control issues

The COVID-19 pandemic has had a significant impact for all provider organisations on their ability to deliver the NHS constitutional standards. The Trust has not delivered the same amount of activity as before due to the significant fluctuations in demand, restrictions on services and the essential infection prevention and control (IPC) measures required to protect our patients and staff. The reduction of elective work in outpatients, surgery, cancer and diagnostics due to COVID-19 has meant that there is a significant rise in the number of patients waiting an excessively long time for their procedure, with an increase in the number of patients waiting more than 52 weeks from 10 to 730 (as at the end of March 2021).

Immediate actions were taken to reduce the impact of COVID-19 on the delivery of care, including cessation of elective work and a significant reduction in diagnostic activity in accordance with national guidance. Urgent and emergency cases continued as normal and cancer surgery and other urgent work was a priority as we worked to reintroduce elective pathways throughout the year.

The clinical teams worked tirelessly to minimise the impact on our patients, routinely carrying out clinical review of waiting lists with specific focus on clinically urgent patients and long waiters. Operational teams developed COVID-19 Protected Standard Operating Procedures, with support from clinical leaders and have developed 'green' pathways and pre-operative testing.

It is important to note the partnership working across the system particularly the hospital discharge program, coordination of PPE supplies and mutual aid programme for intensive care patients. Partnership with local private providers supported our response.

Through proactive management and effective clinical leadership the Trust has reduced the impact of the pandemic on the delivery of constitutional access standards as best it could. Please see the Performance section of the Annual Report for a detailed review of the Trust's achievement of access standards.

7. Conclusion

My review confirms that Surrey and Sussex Healthcare NHS Trust has a sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control. Noting the significant control areas that I have outlined above relating to the delivery of constitutional standards.

Signed.....
Michael Wilson CBE
Chief Executive
Date: 14 JUNE 2021

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

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

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

I confirm that the that the ARA as a whole is fair, balanced and understandable and that I takes personal responsibility for the ARA and the judgments required for determining that it is fair, balanced and understandable.

As far as I am aware, there is no relevant audit information of which the 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 my letter of appointment as an Accountable Officer.

Signed.....

Michael Wilson CBE, Chief Executive

Date.....14 JUNE 2021

Remuneration and staff report including payroll statement

This report includes details regarding senior managers' remuneration in accordance with Section 234b and Schedule 7a of the Companies Act. This includes all regular attendees of Trust Board meetings.

We have an established Nomination and Remuneration Committee to advise and assist the Board in meeting our responsibilities to ensure appropriate remuneration, allowances and terms of service for the chief executive and directors.

Membership of the Committee comprises of the Trust chair and non-executive directors. The chief executive or the other executive directors can be invited to attend in an advisory capacity (except in relation to their own terms and conditions). The director of people and organisational development attends the committee as adviser and is responsible for taking minutes of the meetings.

The chief executive and directors' remuneration is determined on the basis of reports to the remuneration committee taking account of any independent evaluation of the post, national guidance on pay rates and market rates.

Pay rates for other senior managers are determined in accordance with Agenda for Change job evaluations and central NHS review body pay awards. Pay rates for the chair and non-executive directors of the Trust are determined by the Secretary of State and outlined in NHS England / Improvement guidelines. We do not operate any system of performance related pay. The performance of non-executive directors is appraised by the chair.

The performance of the chief executive is appraised by the chair.

The performance of Trust executive directors is appraised by the chief executive.

The chief executive and all directors are on permanent contracts as at 31 March 2021 and subject to six months' notice period. Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements and the NHS pension scheme. Tables attached show details of salaries, allowances and any other remuneration and pension entitlements of senior managers. No significant awards have been made in the past year to senior managers.

The following sections are subject to audit.

Salaries and allowances

Name	Position	2020/21					
		(a) Salary and Fees (bands of £5,000)	(b) Expense payments (taxable) (rounded to nearest £250)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Executive Directors							
Cetti, Edward	Medical Director (and Consultant)	165 - 170	0		0-5	95.0 - 97.5	260 - 265
Dickson, Jane	Chief Nurse	145 - 150	0			82.5 - 85.0	230 - 235
Francis-Musanu, Gillian Josephine	Director of Corporate Affairs	110 - 115	0			55.0 - 57.5	165 - 170
Mackenzie, Ian Duncan	Director of Information and Facilities	105 - 110	0			10.0 - 12.5	115 - 120
Preston, Mark	Director of Organisation Development and People	125 - 130	0			72.5 - 75.0	200 - 205
Simpson, Paul Fraser	Chief Financial Officer	165 - 170	0			60.0 -62.5	225 - 230
Stevenson, Angela	Chief Operating Officer	145 - 150	0			90.0 - 92.5	240 - 245
Wilson, Michael Anthony	Chief Executive	230 - 235	0			-	230 - 235
Non-Executive Directors							
Biddle, Paul	Non-Executive Director	10 - 15	200				10 - 15
Khan, Yasmin	Non-Executive Director	10 - 15					10 - 15
Lambert, Pauline	Non-Executive Director	10 - 15					10 - 15
Sadler, David	Non-Executive Director	10 - 15					10 - 15
Shaw, Richard Oliver	Chairman	35 - 40	400				35 - 40
Swann, Paula	Non-Executive Director	10 - 15					10 - 15
Warner, Caroline	Non-Executive Director	10 - 15					10 - 15

Band of Highest Paid Director's Total Remuneration (£'000)	230 - 235
Mid Point of the Banded Total Remuneration of Highest Paid Director (£'000)	£232,500
Median Total Remuneration	£26,970
Ratio	8.62

Name	Position	2019-20					
		(a) Salary and Fees (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Executive Directors							
Cetti, Edward	Medical Director (and Consultant)	150 - 155	0		0-5	240.0 -242.5	395- 400
Dickson, Jane	Chief Nurse	140 - 145	0			167.5 - 170.0	305 -310
Francis-Muzuru, Gillian Josephine	Director of Corporate Affairs	105 - 110	0			52.5 - 55.0	155 -160
Mackenzie, Ian Duncan	Director of Information and Facilities	105 - 110	0			10.0 - 12.5	115 - 120
Preston, Mark	Director of Organisation Development and Pe	120 - 125	0			40.0 - 42.5	160 -165
Simpson, Paul Fraser	Chief Financial Officer	155 - 160	0			55.0 - 57.5	210 - 215
Stevenson, Angela	Chief Operating Officer	140 - 145	0			82.5 - 85.0	220 - 225
Wilson, Michael Anthony	Chief Executive	210 - 215	0			0	210 - 215
Non-Executive Directors							
Biddle, Paul	Non-Executive Director	5 - 10	700				5 - 10
Khan, Yasmin	Non-Executive Director	5 - 10	0				5 - 10
Lambert, Pauline	Non-Executive Director	5 - 10	500				5 - 10
Sadler, David	Non-Executive Director	5 - 10	200				5 - 10
Shaw, Richard Oliver	Chairman	35 - 40	1200				35 - 40
Swann, Paula	Non-Executive Director	5 - 10	0				5 - 10
Warner, Caroline	Non-Executive Director	5 - 10	100				5 - 10

Band of Highest Paid Director's Total Remuneration (£'000)	210-215
Mid Point of the Banded Total Remuneration of Highest Paid Director (£'000	£212,500
Median Total Remuneration	£24,907
Ratio	8.53

No payments were made to past Directors during the 2020/21 financial year.

Pension benefits

Pension Benefits 2020-21

Name and title	Position	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total Accrued Pension at pension age at 31 March 2021 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5000) £000	(e) Cash Equivalent Transfer Value at 1 April 2020 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2021 £000	(h) Employer's contribution to stakeholder pension £000
Cetti, Edward	Medical Director	5.0 - 7.5	5.0 - 7.5	45 - 50	100 - 105	695	71	802	0
Dickson, Jane	Chief Nurse	2.5 - 5.0	12.5 - 15.0	55 - 60	175 - 180	1,159	108	1,306	0
Stevenson, Angela	Chief Operating Officer	5.0 - 7.5	5.0 - 7.5	60 - 65	145 - 150	1,044	88	1,199	0
Francis-Musanu, Gillian Josephine	Director of Corporate Affairs	2.5 - 5.0	2.5 - 5.0	45 - 50	125 - 130	978	67	1,077	0
Mackenzie, Ian Duncan	Director of Information and Facilities	0.0 - 2.5	2.5 - 5.0	45 - 50	145- 150	1,123	41	1,197	0
Simpson, Paul Fraser	Chief Financial Officer	2.5 - 5.0	10.0 - 12.5	35 - 40	115 -120	855	0	0	0
Preston, Mark	Director of Organisational Development and People	2.5 - 5.0	5.0 - 7.5	40 - 45	85 - 90	715	71	817	0

NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury) 2019	1.70%

Pension Benefits 2019-20

Name and title	Position	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total Accrued Pension at pension age at 31 March 2020 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2020 (bands £000	(e) Cash Equivalent Transfer Value at 1 April 2019 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2020 £000	(h) Employer's contribution to stakeholder pension £000
Cetti, Edward	Medical Director	10.0 - 12.5	27.5 -30.0	40-45	95-100	477	183	695	0
Dickson, Jane	Chief Nurse	7.5 - 10.0	25.0 - 27.5	50-55	155-160	934	162	1,159	0
Stevenson, Angela	Chief Operating Officer	5.0 - 7.5	5.0 - 7.5	55-60	135-140	924	77	1,044	0
Francis-Musanu, Gillian Josephine	Director of Corporate Affairs	2.5 -5.0	2.5 -5.0	40-45	120-125	879	64	978	0
Mackenzie, Ian Duncan	Director of Information and Facilities	0 - 2.5	2.5 - 5.0	45-50	135-140	1,042	42	1,123	0
Simpson, Paul Fraser	Chief Financial Officer	2.5 -5.0	10.0 - 12.5	30-35	100-105	735	80	855	0
Preston, Mark	Director of Organisational Development and People	2.5 -5.0	0.0 - 2.5	35-40	80-85	644	39	715	0

NHSLA publication - Disclosure of Senior Managers Remuneration (Greenbury) 2019	2.4%

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 scheme. The benefits and related Cash Equivalent Transfer Values disclosed do not allow for any potential future adjustments that may arise from this judgement.

Remuneration Notes *

Fair pay disclosure

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

The banded remuneration of the highest paid director within the Trust in the financial year 2020/21 is £230,000-£235,000. This approximates to 8.62 (2019/20 it was 8.53 times) times the median remuneration of the workforce, which is £26,970 (2019/20 £24,907).

The small increase in this ratio derives from the increase in the highest paid director's salary relative to the median salary paid during 2020/21.

The range of staff remuneration (including higher cost area supplement) in 2020/21 was £19,039 to £293,884 In 2019/20 it was £18,669 to £286,314.

The increase in the remuneration of the highest paid Director (the CEO), which is decided by the Trust's remuneration committee, reflects benchmarking of pay rates for other similar positions and the delivery of performance in the year.

The Number of Employees based on the average number of WTE (whole time equivalent including temporary workers) at the Trust rose from 4,620 in 2019/20 to 4,798 in 2020/21.

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

Analysis of gender review of Trust Directors and Non executive Directors

	Female	Male
Executive Directors (8)	3 (38%)	5 (62%)
Non Executive Directors (7)	4 (57%)	3 (43%)
Total	7 (47%)	8 (53%)

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

Please refer to the section below and in the section on Our People earlier in this report for:

- Detail on our staff composition including the gender pay gap
- Diversity and equal treatment
- Partnership working including with trade unions
- Our policies for ensuring fair treatment of people with a disability.

Data on sickness absence rates is published by NHS Digital. Please see https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Turnover

As at the end of March 2021, our overall turnover rate was 12.29% for all staff groups and 13.07% for nursing and midwifery staff. We have made significant improvements in our turnover rates over the past three years (our overall turnover rate in March 2018 was 16.1%, with Nursing & Midwifery at 17.3%). We have focussed on both our recruitment and retention of staff and have seen our vacancy rate reduce across the same period – we have employed more substantive staff and reduced our reliance on temporary staffing solutions. We have an active international recruitment plan in place but we have also undertaken more targeted local recruitment which we are now seeing the benefits of. We acknowledge there have been challenges, especially in regard to the high cost of living in the locality, but we are working on plans to address these and are confident we will continue to see an improved position in our turnover.

Disability

SASH continues to actively participate in the disability confident employer scheme and has recruitment policies and practices that support the attraction and recruitment of disabled people. SASH has developed the SASH-Ability passport which is designed for colleagues with a long term health condition/disability to help with accessing the support required in the workplace. It aims to support staff to manage their health condition and disability at work; removing obstacles in communicating their situation, particularly as they join the Trust or change roles. We have also introduced the Sunflower Scheme which supports staff, patients and visitors with hidden disabilities. We continue to collaborate with partner organisations, such as Access to Work, to support disabled staff in the workplace. Our work is overseen by the Trust's Inclusion Steering Group and supported by our newly appointed Head of Inclusion.

How policies and activities undertaken in the year have or will improve the diversity and inclusiveness of the workforce

We have an on-going review cycle for all Trust policies including people policies. This ensures they are legally compliant and follow best practice. All policies require an Equality Impact Assessment to be completed and our Head of Inclusion is developing additional support for policy 'authors' to ensure the EIAs are meaningful and have impact. Our people policies are reviewed in partnership with staff side colleagues and then approved at our Well-Led committee. This process ensures open and transparent policy development that focusses on inclusion and diversity.

We have used the learnings from the People Practices review, along with our own data, to further develop our Disciplinary Policy, and we use feedback, for example from the WRES and the national staff survey to identity areas where other policies and procedures can be improved to enhance staff experience. We are always looking to improve our offer to staff and we received feedback from colleagues in our

BAME Staff Network that our annual leave policy guidance about taking block periods off felt restrictive for staff who have entire families overseas. The workforce team and the head of inclusion worked together to amend the narrative in the annual leave policy to ensure due consideration for these colleagues.

The Trust introduced career prospects workshops to help staff at Band 5 develop their career trajectories and explore opportunities that are available to them. This particularly supports our staff who join us from overseas and supports them in identifying practical steps to aid their longer term career progression.

Whether the entity has identified any barriers to improving the diversity of its workforce and if so, what actions the entity has or will put in place
SASH is proud that we have one of the highest levels of BAME staff employed at our Trust in the region. We have an active BAME Staff Network and have recently established an LGBT+ Network. The Trust Inclusion Steering Group meets monthly to develop the agenda for Inclusion across SASH and we established and appointed to our new head of Inclusion post in January 2021. These provide the assurance to support inclusion and diversity at SASH.

Operationally we have used the WRES and WDES data to make changes to our policies and procedures and we are currently reviewing our recruitment and selection process as well as our succession planning and talent management programmes to ensure these provide fair and equal access to our staff and those wishing to join our organisation.

We have reviewed our Bursary application process, (sponsorship for external courses), to ensure this is inclusive and we have seen a higher proportion of BAME staff being awarded bursaries than their total proportion in the Trust.

Changes in staff composition impacting on the diversity and inclusiveness of the workforce, including appropriate trend data.
We produce an annual Equality & Diversity report which we publish on our external website. This includes the trend data across a number of the protected characteristics and highlights our SASH population in comparison with previous years as well as with our local census data for the communities we serve. We have seen an increase in staff declarations in regard to the protected characteristics which helps provide greater definition for our data.

37.40% of our staff are BAME, and we have seen that increase year on year. As with most NHS Trusts, the significant majority of our staff are female (74.90%). In terms of our age profile the highest number of staff are aged between 31-40. We have performed well overall in the Gender Pay Gap analysis, however there is more to do in regard to this as well as analysing any pay gap in terms of ethnicity. Over 69% of our staff state they are heterosexual with 1.07% LGBT and 0.54% bisexual – 23% of our staff have not made any declaration. In terms of religion, the highest recorded was Christian, (44.8%), although 27% of staff have not declared.

Only 60 staff, (headcount), state they have a disability as recorded on the Electronic Staff Record, although 13% of our staff have stated that have a disability or long term health condition on the 2020 National Staff Survey. We are reviewing ways we can further encourage staff to declare disabilities so we can ensure we have the relevant support in place.

Performance against internal targets set in relation to diversity and inclusiveness of the workforce if applicable.
We are currently developing a set of internal KPIs as part of our 'refresh' of our SASH One team Inclusion Plan. We do however use benchmarked data such as the WRES/WDES to inform us of required actions. We are making positive progress in line with the NHSE Model Employer briefing and we will further develop this as part of the work we are undertaking in line with the recently published Race Disparity ratio.

Compensation on early retirement or for loss of office
We have not made any payments in regards to these categories.

Consultancy spend in 2020/21

Consultancy expenditure during 2020/21 totalled £62k and is itemised as below:

Consultancy fees	£000's	Provider	Description
Service Improvement	34	Carnall Farrar Ltd	Financial recovery plan development work
Health Informatics	4	Various	Health Informatic service and associated costs
Maternity	24	Nautilus Consulting Ltd	Maternity IT system procurement
Total	62		

Facility time publication requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017.

In line with the Regulations, Surrey and Sussex Healthcare Trust is required to publish the following information relating to trade union officials and facility time, which is agreed time off from an individual's job to carry out a trade union role.

Table 1: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Average number of Whole-time equivalent employee number (including

	temporary workers)
33	4,798 (including 539 WTE temporary workers)

Table 2: Percentage of time spend on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0-50%, b) 51-99%, c)100% of their time on facility time?

Percentage of time	Number of employees
0%	0
1-50%	33
51% - 99%	0
100%	0

Table 3: Percentage of pay bill spend on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

Provide the total cost of the facility time. (year)	£1,923
Provide the total pay bill (year)	£264,806,000

Provide the percentage of the total pay bill spent on facility time, calculated as : **(Total cost of facility time ÷ total pay bill)x100**	0.0007%

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as : **(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid**	11.4%

facility time hours) x 100	

The following sections are subject to audit.

Staff costs

	Permanent	Other	2020/21	2019/20
	£000	£000	**£000**	£000
Salaries and wages	178,643	24,519	**203,162**	179,717
Social security costs	18,674	2,273	**20,947**	18,680
Apprenticeship levy	967	0	**967**	882
Employer's contributions to NHS pension scheme	28,727	3,192	**31,919**	29,231
Temporary staff	0	10,381	**10,381**	14,757
Total gross staff costs	227,011	40,365	**267,376**	243,267
Recoveries in respect of seconded staff	(2,570)	0	**(2,570)**	(2,740)
Total staff costs	224,441	40,365	**264,806**	240,527
Of which	£000	£000	**£000**	£000
Costs capitalised as part of assets	240	84	**324**	240

Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 total number	2019/20 total number
Medical and dental	674	71	745	685
Administration and estates	972	103	1,075	940
Healthcare assistants and other support staff	753	114	867	954
Nursing, midwifery and health visiting staff	1,325	213	1,538	1,500
Nursing, midwifery and health visiting learners	9	-	9	4
Scientific, therapeutic and technical staff	553	46	599	453
Healthcare science staff	-	-	-	84
Total average numbers	**4,286**	**547**	**4,833**	**4,620**
Of which:				
Number of employees (WTE) engaged on capital projects	4	1	5	4

Reporting of compensation schemes - exit packages 2020/21			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	-	3	3
£10,000 - £25,000	-	1	1
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	4	4
Total cost (£)	£0	£27,000	£27,000
Reporting of compensation schemes - exit packages 2019/20			

		Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)				
<£10,000		-	1	1
£10,000 - £25,000		-	-	-
£25,001 - 50,000		-	-	-
£50,001 - £100,000		-	-	-
£100,001 - £150,000		-	-	-
£150,001 - £200,000		-	-	-
>£200,000		-	-	-
Total number of exit packages by type		-	1	1
Total resource cost (£)		£0	£10,000	£10,000
Exit packages: other (non-compulsory) departure payments				

	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	4	27	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**4**	**27**	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

No off- payroll engagements whereby individuals are paid through their own companies were made during the 2020-21 financial year.

Signed:  **Date:** 14 JUNE 2021

Michael Wilson CBE
Chief executive

Our finances

The year in context

The Trust ended 2020/21 with a breakeven financial position (strictly speaking a £47k surplus) after allowable technical items (including revaluation impairments and donated asset adjustments) were taken into account.

Throughout 2020/21 all NHS trusts have been working to a special finance regime that is very different from the finance regime operated in 2019/20. That was implemented in March 2020 to allow adequate funding for the NHS as it managed COVID. The break-even position meets the Trust's plan for the year and the expectations of NHS England/ Improvement (NHSE/I) within that finance regime.

In summary, the Trust:

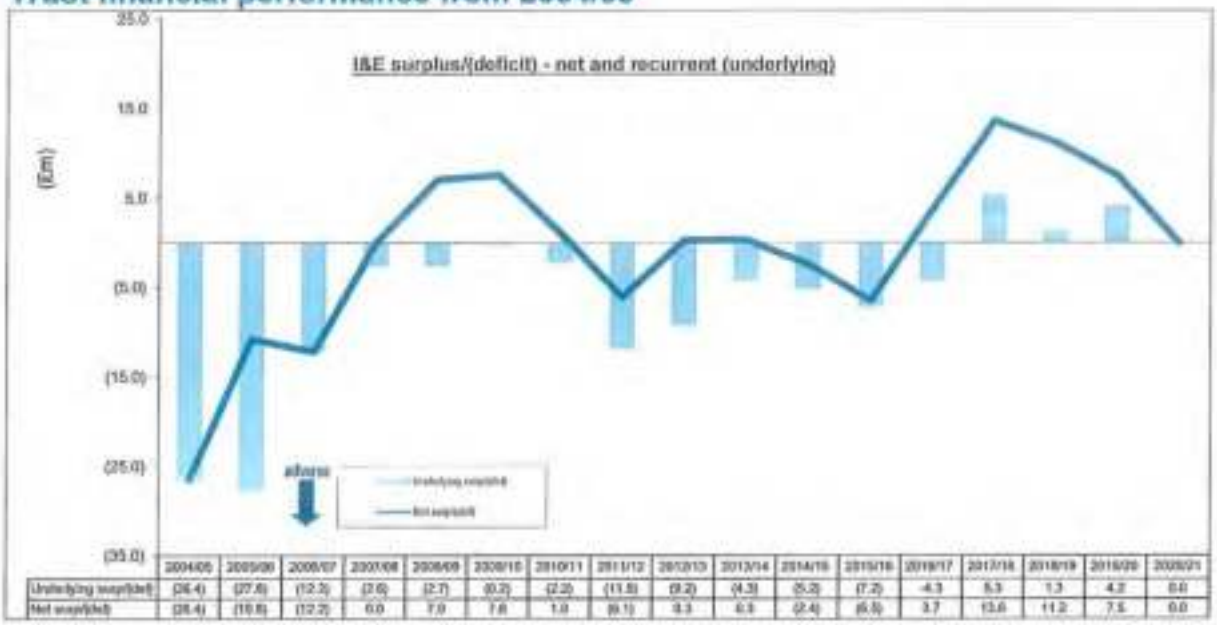
- ✓ Managed its expenditure within the available resources provided through a block-payment (a fixed monthly payment for core costs) and the various 'top-up' payments to balance other costs and costs directly related to COVID;
- ✓ Received personal protective equipment (PPE) and medical device equipment (including ventilators) directly provided by DHSC with a financial value of £7.1m;
- ✓ Maintained its working capital position (indeed the timing of cash-flows left it with more cash in the bank at the end of the year than the start, but that is an artefact of those payments being provided early to avoid cash problems for trusts);
- ✓ Stayed within its External Financing Limit (EFL);
- ✓ Stayed within its Capital Resource Limit (CRL), with a capital spend of £22.2m – our largest annual capital spend, with significant additional investment to equip the Trust to manage COVID and the post-COVID healthcare environment (for example £1.7m provided to ensure our oxygen supply) ;
- ✓ Delivered its Better Payment Practice Code (BPPC) target of 95% of bills paid within 30 days (the third year that the Trust has achieved that) – exceeding that overall by achieving 97% by volume and 96% by price (this ensured prompt payment to suppliers during the COVID year);

Financial performance since the Trust's creation

Income and expenditure performance is described in the chart below, which provides a view back to 2004/05.

The 2020/21 financial regime was designed to allow NHS providers to breakeven in 2020/21, which the Trust successfully achieved. This financial regime has been extended to the first half of 2021/22 with a requirement to breakeven at the end of the period. More information about the COVID finance regime is provided later.

Trust financial performance from 2004/05



	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Underlying surplus/(deficit)	(26.4)	(27.6)	(12.3)	(2.6)	(2.7)	(0.2)	(2.2)	(11.8)	(9.2)	(4.3)	(5.2)	(7.2)	4.3	5.3	1.3	4.2	0.0
Net surplus/(deficit)	(26.4)	(10.8)	(12.3)	0.0	7.9	7.8	1.0	(9.1)	9.3	0.3	(2.4)	(6.5)	3.7	13.6	11.2	7.5	0.0

National cost collection index and cost per weighted activity unit
The Trust continues to be one of the lowest cost acute trusts in England. The Trust's 2019/20 (most recent numbers) cost per weighted activity unit (WAU) is the 5th lowest for any acute trust nationally (£3,044 per WAU).

The Model Hospital work on trust operational productivity and efficiency has used the national cost collection index to create a cost per weighted activity unit (WAU) measure. This is a value describing the cost to deliver the treatments carried out for patients, as adjusted and weighted for complexity of treatment. This is then compared with costs per WAU across the country. The Trust has a cost per weighted activity unit of £3,044, the 5th lowest unit cost in England for an acute trust.

Trust cost metrics

	Reference cost/national cost collection index	Adjusted treatment cost (£)	Cost (£) per weighted activity unit
2006/07	116		
2007/08	95		
2008/09	86		
2009/10	94		
2010/11	97		
2011/12	89		
2012/13	92		
2013/14	92		
2014/15	88	£0.88	
2015/16	86		£3,010
2016/17	83		£2,930
2017/18	83		£2,903
2018/19	82		£2,791
2019/20	not yet available		£3,044

Cost per weighted activity unit

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

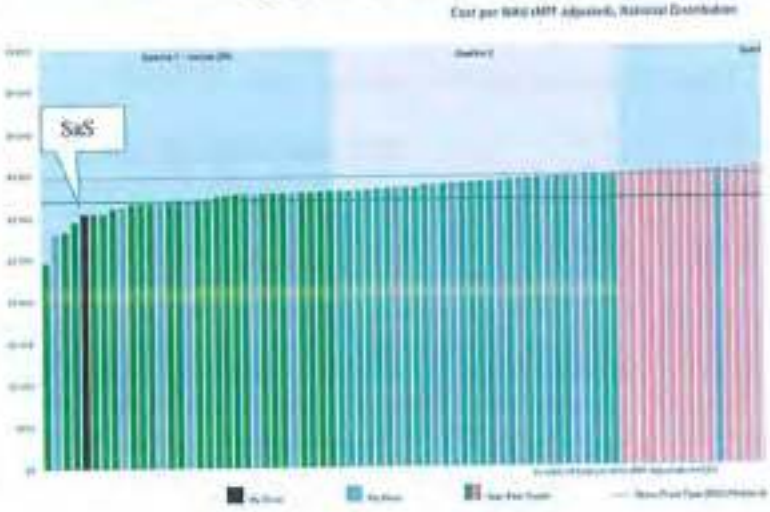
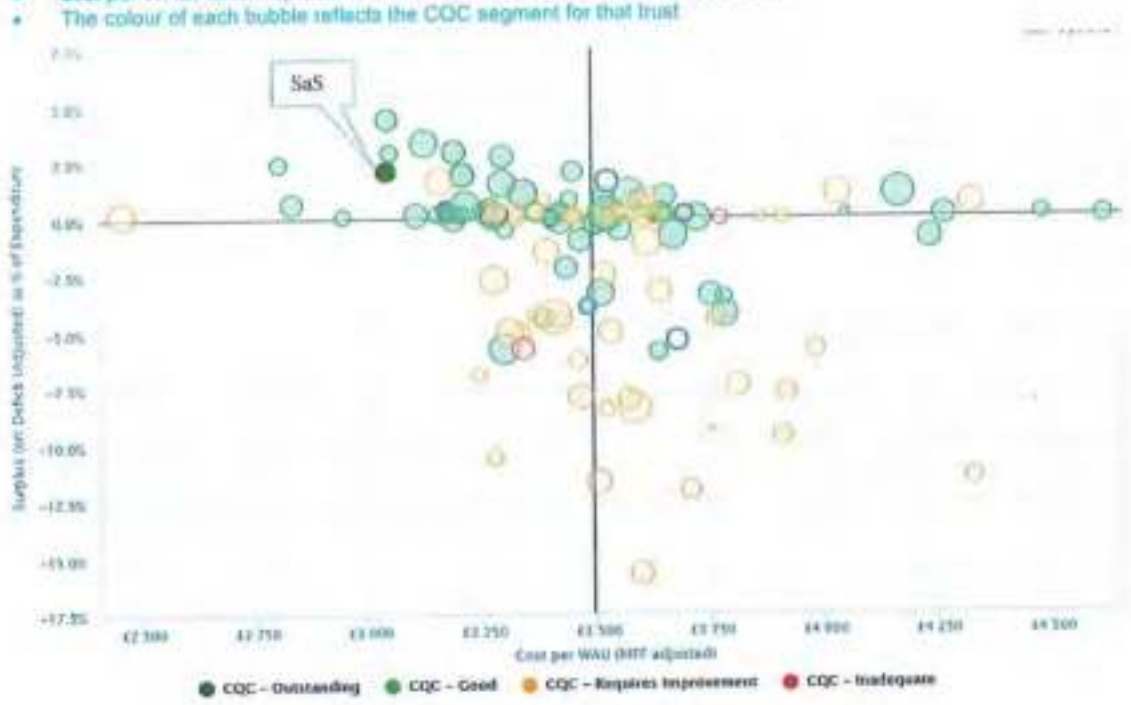


Chart: Model Hospital Quality, Efficiency, Deficit (QED) chart

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

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



Click on the above legend to turn on or off the different CQC segments of trusts.
Bubble size is Cost Weighted Output expressed as Weighted Activity Units (WAUs)

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

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

The Model Hospital data shows that the Trust has one of the lowest overall productivity gains to achieve when benchmarked against other English trusts.

Agency costs reduced further in the COVID year

Total agency spend in 2020/21 amounted to £10.4m. This compares to £14.8m in 2019/20, a year on year reduction of £4.4m, despite staff sickness from COVID or self-isolation, but also noting that agency availability was affected for the same reason.

The main driver of this reduction is from nursing agency, which cost the Trust £6.1m in 2019/20 and reduced to £2.8m in 2020/21 (that's a £3.3m reduction, so over 50%).

During 2019/20 the Trust invested significantly in overseas recruitment of permanent staff. The cost of their recruitment, on-boarding and double running while being trained totaled £6.5m. The Trust increased the rates paid to workers on the Trust's nurse bank (people willing to work additional hours or temporarily on Trust rates of pay) and recast its commercial arrangements for agency suppliers. The combination of these measures resulted in a very low nurse vacancy rate and the significant reduction in nurse agency costs.

That also helped the Trust as it entered the COVID year, and even with the suspension of overseas recruitment we were able to cope with staff turnover during the year, and the very high rates of staff sickness.

Further information on the Trust's approach to improving its productivity and efficiency is set out elsewhere in this Annual Report, including the section describing our SaSH+ programme.

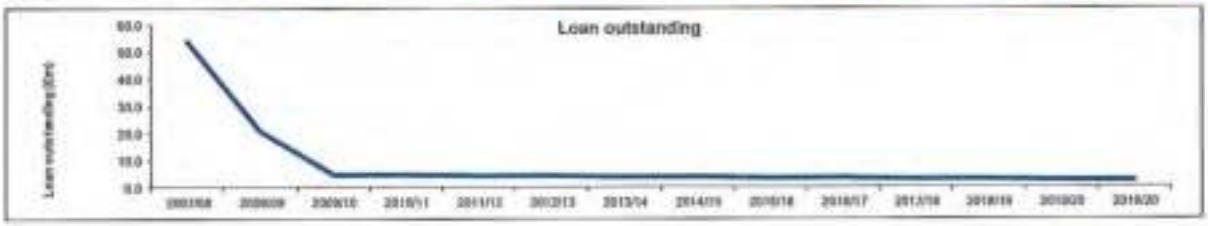
The original loan and the statutory breakeven duty

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

The current position on the loan is described below, with £2.4m left outstanding. The Trust is now making the scheduled payments required by its 25 year loan agreement against that balance.

Loan repayment schedule

Loan repayment plan														
Loan outstanding b/fwd														
Conversion to PDC														
Trust repayment														
Loan carried forward														



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

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

COVID interrupts financial planning and requires a different approach

2020/21 has obviously been a very different year from any before. NHSE/I acted quickly in March 2020 to stop NHS contracting and the financial planning process, and introduced the COVID finance regime (replacing the 'normal' regime of the national tariff payment system providing income based on activity managed through a locally agreed contract with CCGs).

In response, financial management in SaSH has been focused on control of expenditure (and maintaining rigour in financial decision making) while allowing fast response to legitimate requests for additional funding. An internal audit report provided "substantial assurance" to the Trust's Audit and Assurance Committee and concluded:

> The Trust did not make any significant changes to financial processes in response to Covid-19 that would have resulted in additional financial risk during this period. Covid-19 expenditure has been well monitored on the

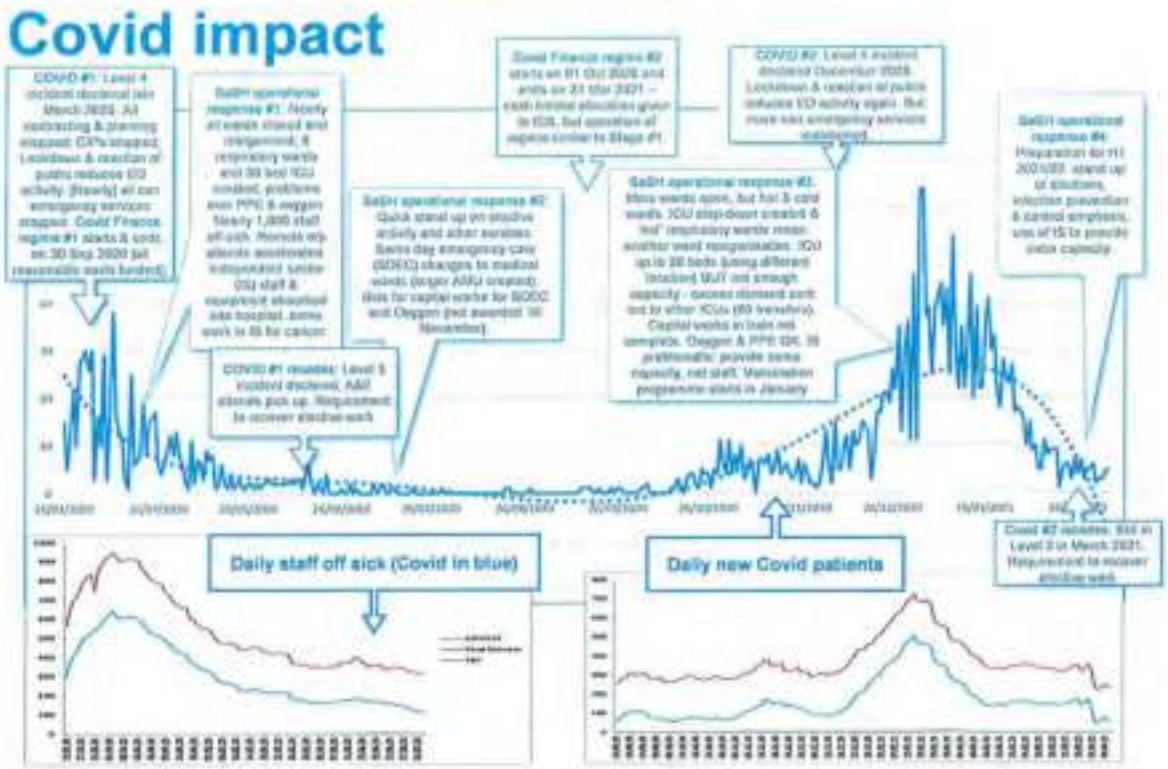
financial system and approved in line with HFMA [*Healthcare Financial Management Association*] guidance, with additional oversight provided by the Trust finance Team and the Chief Financial Officer. Meetings between key staff and Committees such as the Finance and Workforce Committee were held remotely in accordance with the guidance. There were no changes in Payroll processes at the Trust during the Covid-19 period and the Trust was compliant with payment timescales by invoice value and invoice number.

The COVID finance regime

The COVID finance regime consists (simplistically) of a block contract, a contract top-up and another top-up for COVID costs. In the first half of the year funding was provided to deliver breakeven, in the second half of the year similar mechanics applied but financial envelopes at ICS level restricted the funding available (so a trust could have a deficit if it did not manage its expenditure). The funding provided was calculated by NHSE/I, in the second half of the year the Integrated care System (ICS) agreed funding envelopes and final payments.

The continual change in Trust services in response to the COVID waves as they came and receded, the switching on-and-off of costs, the difficulty of identifying recurrent and non-recurrent impacts and the lack of prior experience of this situation did require continued focus. The finance team in the Trust should be commended for how they responded, and they also faced periods with staff members off-sick with COVID. The chart below tries to encapsulate in one diagram the ebb and flow and how Trust services were impacted

Chart: The different phases of the COVID year



Although the Trust did achieve efficiency benefit in the year (as reported above from agency expenditure, and also from procurement), in line with national guidance, the Trust did not operate its normal a waste reduction (savings) plan process with Divisions.

Expenditure on COVID related costs, or cost related to recovery and reinstating elective work was recorded and submitted each month as part of the NHSE/I provider financial reporting (PFR) process and is reported along with other trusts through the ICS Strategic Finance Assurance Board.

2021/22 financial plans: continuation of the COVID Finance Regime

With the impact of the second wave, NHS England/Improvement has 'rolled forward' the COVID finance regime from the 2nd half of 2020/21, and again there has been an abandonment of contracting with CCGs and the pre-COVID 'normal' financial planning round. This means that ICS's are overseeing an allocation which provides a block contract to the Trust with top-ups, including COVID funding. The regime is in place formally until the end of September (so H1), and NHS England/Improvement has not advised what will replace it in H2 (although it is increasingly likely that it will be a similar approach, perhaps with some adjustment on the way to a return to full year planning from April 2022 – which is being called a 'glide-path').

One difference from 2020/21 is the implementation of an elective recovery fund, which is intended to incentivise elective work above the 2019/20 activity baseline to start to reduce the significant backlog of elective cases. Nationally that is many millions of people waiting for treatments and procedures, some for over 52 weeks.

Planning returns, for the first half of 2021/22, are coordinated through the ICS, with a non-mandatory submission from individual providers in June 2021. This Trust has previously submitted a breakeven plan, and planned, within that, to deliver above 100% of its elective baseline by July 2021. The Trust, and ICS, will monitor the position as it has throughout the previous year and as this is written (during the finalisation of Month 2 financial reports) there are signs that the Trust and ICS are delivering strongly against the elective recovery fund, suggesting performance better than breakeven in H1. Finally, the Surrey Heartlands ICS has also been asked to submit an 'accelerator bid' to further increase elective work. If successful this would provide additional capital and revenue funding to this Trust and with an expectation of delivering at least 110% of the elective baseline by July 2021.

Analysis of financial data

The table below provides a summary of our income and expenditure performance since 2010/11, using the EBITDA* presentation.

Detail of overall income and expenditure performance since 2010/11

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

Income & Expenditure: EBITDA presentation	2010/11 (£m)	2011/12 (£m)	2012/13 (£m)	2013/14 (£m)	2014/15 (£m)	2015/16 (£m)	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	2019/20 (£m)	2020/21 (£m)
Income from patient care	170.0	189.3	197.0	210.0	224.8	240.9	258.0	283.9	304.6	342.2	302.3
Other operating income	16.4	20.3	29.0	20.8	19.0	24.0	26.4	31.6	31.3	29.9	34.5
Net operating income	186.2	209.6	226.0	231.4	243.8	264.9	284.3	315.4	335.9	372.1	336.8
Operating expenses	(167.2)	(197.0)	(215.0)	(220.4)	(234.5)	(258.2)	(268.4)	(286.8)	(309.3)	(348.3)	(301.0)
EBITDA (op surplus/(deficit))	9.0	2.6	11.0	11.0	9.3	6.7	17.9	28.6	26.6	23.8	15.8
Net interest and other items	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.5)	(1.0)	(0.8)	(0.5)	(0.7)	(0.3)
Depreciation/amortisation	(4.7)	(5.4)	(7.2)	(7.2)	(7.5)	(8.7)	(9.2)	(9.4)	(9.6)	(10.1)	(10.5)
PDC dividends payable	(3.0)	(3.0)	(3.1)	(3.2)	(3.0)	(3.0)	(4.1)	(4.2)	(5.3)	(5.2)	(4.9)
Impairments/donated assets											
NHS performance surplus/(deficit)	1.0	(6.1)	0.3	0.3	(2.4)	(5.5)	3.7	13.6	11.2	7.5	0.0
Technical adjustments	(4.8)	0.0	0.1	0.0	0.0	2.4	(0.2)	0.0	0.0	(0.4)	(1.1)
NET SURPLUS/(DEFICIT)	(3.7)	(6.1)	0.4	0.3	(2.4)	(4.1)	3.4	13.6	11.2	7.1	(1.1)
Underlying surplus/(deficit)	(2.2)	(11.3)	(9.3)	(6.3)	(8.3)	(7.2)	(4.2)	7.9	1.3	4.2	0.0
Break even duty: Cumulative deficit	(39.4)	(44.5)	(44.2)	(43.9)	(46.3)	(53.0)	(49.2)	(35.6)	(24.3)	(16.8)	(16.8)

Capital

In 2020/21 the Trust has spent £22.2m (the largest annual capital spend, in any year – the previous highest was the £19.3m spent in 2014/15). Of that total only £10.9m was generated from depreciation (providing our 'core' capital spend), the remainder was funded from additional capital resource limit funding provided by NHSE/I, to deliver our e-SASH programme and fund various COVID related projects.

The key points from the capital programme are as follows:

1. **Digital infrastructure:** The largest area of spend was £4.9m on digital infrastructure (mainly e-SaSH EPR [electronic patient record] and EPMA [electronic prescribing and medicines administration] systems) which takes the Trust further forward on our digital journey.

2. **VIE:** The oxygen problems of the original COVID wave are being resolved through the £1.7m installation of the Trust's 2nd VIE (vacuum insulated evaporator, a pressure vessel for cryogenic gases) and the creation of a 'ring-main' piping system.

3. **Neonatal unit finished:** A large project in the last year, £0.8m was spent on the neonatal unit early in the year to complete it.

4. **Fixed allocations, hospital infrastructure and divisional spend:** More mundane but important spend on fixed allocations (IT hardware, endoscopy and medical equipment) cost £2.1m, and essential estates infrastructure work cost £2.7m (with £1.2m spent on the high voltage solution). The divisions spent a combined £3.5m on a range of smaller priority projects in their respective areas

5. **COVID capital:** the COVID year has seen the Trust buying equipment and infrastructure (like generators to meet the safety requirements of continuous power for the new ICU areas we opened) and COVID capital purchases cost £1.7m. The sign off process within the Trust, and the nature of what we bought (all of it was justifiable) meant that nearly all of what we claimed was approved for funding albeit very late in the year).

6. **Ward budgets:** In previous years the ward improvement budget has tended to be depleted as other priorities came along, but this year we spent £0.9m improving the wards.

7. **'New projects':** These are the projects to support Trust capacity post COVID which have been funded by NHSE/I, although augmented with Trust sourced capital. These included the Same Day Emergency Care unit, greater capacity in endoscopy project and an additional ICU room.

Conclusion

Keep in touch

Surrey and Sussex Healthcare NHS Trust
Trust Headquarters
Canada Avenue
Redhill
Surrey
RH1 5RH
01737 768511
www.surreyandsussex.nhs.uk

Twitter: @SASHnhs

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

East Surrey Hospital

Redhill
Surrey
RH1 5RH
01737 768511

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

Crawley Hospital

Crawley
West Sussex
RH11 7DH
01293 600300

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

Caterham Dene Hospital

Church Road
Caterham
Surrey
CR3 5RA
01883 837500

Horsham Hospital

Hurst Road
Horsham
West Sussex
RH12 2DR
01403 227000

The Earlswood Centre

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

Need help or advice?

The Patient Advice and Liaison Service (PALS) focuses on improving services for NHS patients. It aims to: advise and support patients, their families and carers, provide information on NHS services, listen to concerns, suggestions or queries from our patients and the people we care for and help sort out problems quickly on their behalf.

Contact PALS: 01737 768511 x1958 (for all sites) sash.pals@nhs.net PALS, East Surrey Hospital, Redhill, Surrey, RH1 5RH You can ask a member of staff to contact PALS on your behalf This information is available in other languages and formats including audio tape, large print and braille. For further information please contact PALS (Patient Advisory Liaison Service) on 01737 231958 or email: sash.pals@nhs.net

Independent auditors' report to the Directors of Surrey and Sussex Healthcare NHS Trust

Report on the audit of the financial statements

Opinion

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

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

We have audited the financial statements, included within the Annual Report 2020-21 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2021; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the Local Audit and Accountability Act 2014, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

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

Conclusions relating to going concern

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the directors use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

However, because not all future events or conditions can be predicted, this conclusion is not a guarantee as to the Trust's ability to continue as a going concern.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Reporting on other information

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

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

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the Department of Health and Social Care Group Accounting Manual 2020/21 have been included.

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

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2021 is consistent with the financial statements and has been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

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

In addition, the parts of the Remuneration and Staff reports required to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21 and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditors' responsibilities for the audit of the financial statements

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

irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

Based on our understanding of the Trust and industry, we identified that the principal risks of non-compliance with laws and regulations related to the Data Protection Act 2018, and we considered the extent to which non-compliance might have a material effect on the financial statements. We also considered those laws and regulations that have a direct impact on the financial statements such as the National Health Service Act 2006 and related legislation governing NHS Trusts. We evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls), and determined that the principal risks were related to the use of journals to manipulate financial performance and overstate costs to claim COVID-19 funding during the year as well as year-end top up funding. Audit procedures performed by the engagement team included:

- identifying and testing journal entries using a risk based targeting approach for unexpected account combinations;
- testing a sample of COVID-19 related expenditure to supporting documentation to verify that the Trust had correctly included expenditure that related to COVID-19 costs;
- testing a sample of accounts payable and accruals at the year-end by agreeing the amount recognised to the subsequent invoice or other relevant supporting documentation including contracts or calculations and agreed estimates and assumptions used to previous charges for the goods/services to check the amount and timing of recognition of the expense; and
- enquiring throughout the year with management, internal audit, local counter fraud specialist and those charged with governance to understand the relevant laws and regulations applicable to the Trust, including their assessment of fraud related risks and consideration of known or suspected instances of non-compliance with laws and regulations.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

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

Use of this report

This report, including the opinions, has been prepared for and only for the Directors of Surrey and Sussex Healthcare NHS Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

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

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

Under the Code of Audit Practice we are required to report, by exception, whether any significant weaknesses were identified during our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources, and to refer to any associated recommendations. As explained further in our Auditor's Annual Report, our work was performed in the context of the COVID-19 pandemic and resulting changes in both the operating and financing regimes for the NHS for the year.

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

Other matters on which we report by exception

We are required to report to you if, in our opinion:

- we have referred a matter to the Secretary of State for Health under section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under section 24 of the Local Audit and Accountability Act 2014.
- we have made written recommendations to the Trust under section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of, the audit.
- we have not received all of the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of section 21 of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Sasha Lewis (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Southampton
15 June 2021

Surrey and Sussex Healthcare NHS Trust

Annual accounts for the year ended 31 March 2021

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

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

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

As far as I am aware, there is no relevant audit information of which the 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 my letter of appointment as an Accountable Officer.

Signed.....

Michael Wilson CBE

Chief Executive

Date 14th June 2021

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Signed ..... Signed .....

Michael Wilson CBE

Chief Executive

Date 14th June 2021

Paul Simpson

Chief Financial Officer

Date 14th June 2021

Statement of Comprehensive Income

for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	348,729	342,225
Other operating income	4	48,215	30,254
Operating expenses	6	(390,868)	(358,767)
Operating surplus from continuing operations		**4,076**	**13,712**
Finance income	11	6	160
Finance expenses	12	(306)	(447)
PDC dividends payable		(4,872)	(5,491)
Net finance costs		**(5,172)**	**(5,778)**
Other gains / (losses)	13	-	(437)
(Deficit) / surplus for the year from continuing operations		**(1,096)**	**7,497**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(178)	-
Revaluations	17	250	2,757
Total comprehensive (expense) / income for the period		**(1,024)**	**10,254**

Statement of Financial Position

As at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	5,112	1,862
Property, plant and equipment	15	205,463	198,391
Receivables	19	5,201	5,166
Total non-current assets		**215,776**	**205,419**
Current assets			
Inventories	18	4,634	4,641
Receivables	19	10,397	18,690
Cash and cash equivalents	20	36,964	16,541
Total current assets		**51,995**	**39,872**
Current liabilities			
Trade and other payables	21	(43,199)	(30,510)
Borrowings	23	(1,653)	(1,949)
Provisions	25	(1,767)	(301)
Other liabilities	22	(1,641)	(2,818)
Total current liabilities		**(48,260)**	**(35,578)**
Total assets less current liabilities		**219,511**	**209,713**
Non-current liabilities			
Trade and other payables	21	(2,883)	(2,993)
Borrowings	23	(7,206)	(8,600)
Provisions	25	(2,638)	(2,536)
Total non-current liabilities		**(12,727)**	**(14,129)**
Total assets employed		**206,784**	**195,584**
Financed by			
Public dividend capital		174,112	161,888
Revaluation reserve		51,852	53,060
Income and expenditure reserve		(19,180)	(19,364)
Total taxpayers' equity		**206,784**	**195,584**

The notes on pages to form part of these accounts.

Signature:

Name **Michael Wilson CBE**
Position **Chief Executive Officer**
Date 14th June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	161,888	53,060	(19,364)	195,584
Surplus/(deficit) for the year	-	-	(1,096)	(1,096)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,280)	1,280	-
Impairments	-	(178)	-	(178)
Revaluations	-	250	-	250
Public dividend capital received	12,224	-	-	12,224
Taxpayers' and others' equity at 31 March 2021	174,112	51,852	(19,180)	206,784

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	157,570	51,542	(28,100)	181,012
Surplus/(deficit) for the year	-	-	7,497	7,497
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,239)	1,239	-
Revaluations	-	2,757	-	2,757
Public dividend capital received	4,318	-	-	4,318
Taxpayers' and others' equity at 31 March 2020	161,888	53,060	(19,364)	195,584

Surrey and Sussex Healthcare NHS Trust

Annual accounts for the year ended 31 March 2021

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Date 14th June 2021

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By order of the Board

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Michael Wilson CBE

Chief Executive

Date 14th June 2021

Paul Simpson

Chief Financial Officer

Date 14th June 2021

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for the year ended 31 March 2021

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Total taxpayers' equity		**206,784**	**195,584**

The notes on pages to form part of these accounts.

Signature: .....

Name: Michael Wilson CBE
Position: Chief Executive Officer
Date: 14th June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	161,888	53,060	(19,364)	195,584
Surplus/(deficit) for the year	-	-	(1,096)	(1,096)
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Impairments	-	(178)	-	(178)
Revaluations	-	250	-	250
Public dividend capital received	12,224	-	-	12,224
Taxpayers' and others' equity at 31 March 2021	174,112	51,852	(19,180)	206,784

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
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Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,239)	1,239	-
Revaluations	-	2,757	-	2,757
Public dividend capital received	4,318	-	-	4,318
axpayers' and others' equity at 31 March 2020	161,888	53,060	(19,364)	195,584

Information on reserves

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

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

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

Statement of Cash Flows

for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus		4,076	13,712
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,607	10,309
Net impairments	7	2,176	-
Income recognised in respect of capital donations	4	(883)	(153)
(Increase) / decrease in receivables and other assets		8,791	4,131
(Increase) / decrease in inventories		7	(287)
Increase / (decrease) in payables and other liabilities		10,101	5,557
Increase / (decrease) in provisions		1,578	798
Net cash flows from operating activities		**36,453**	**34,067**
Cash flows from investing activities			
Interest received		6	160
Purchase of intangible assets		(3,946)	(556)
Purchase of PPE		(17,039)	(14,854)
Sales of PPE		-	200
Receipt of cash donations to purchase assets		136	153
Net cash flows (used in) investing activities		**(20,843)**	**(14,897)**
Cash flows from financing activities			
Public dividend capital received		12,224	4,318
Movement on loans from DHSC		(1,319)	(10,362)
Capital element of finance lease rental payments		(358)	(765)
Interest on loans		(210)	(338)
Interest paid on finance lease liabilities		(119)	(107)
PDC dividend (paid)		(5,405)	(5,520)
Net cash flows from / (used in) financing activities		**4,813**	**(12,774)**
Increase in cash and cash equivalents		**20,423**	**6,396**
Cash and cash equivalents at 1 April - brought forward		**16,541**	**10,145**
Cash and cash equivalents at 31 March	20.1	**36,964**	**16,541**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 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.

Surrey and Sussex Healthcare NHS Trust is the Corporate Trustee of SASH Charity. The charity is deemed to be a subsidary under the prescriptions of IAS27. International Acounting Standards dictate that consolidated accounts should be prepared. IAS1 Presentation of Accounts however states that specific disclosure requirements to be set out in individual standards or interpretations need not be satisfied if the information is not material. Furthermore, accounting policies set out in IFRS need not be developed or applied if the impact of applying them would be immaterial.

Whilst Surrey and Sussex Healthcare NHS Trust does have a connected Charitable Fund, it does not deem this fund material within the context of the accounts of the Trust.

Surrey and Sussex Healthcare NHS Trust is the sole beneficary of the SASH Charity (registration number 1054072). For the year ended 31st March 2021 the charity received income of £710k, expenses were £458k and had total assets of £1,211k and total liabilities of £64k (subject to audit review).

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block contract and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

NHS injury cost recovery scheme

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

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a 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, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control

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

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

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

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Impairments

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

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

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

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

Note 1.8 Intangible assets

Recognition

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

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	5	5

Note 1.9 Inventories

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

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

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.

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

From year on year review of debt payment, according to type of debt and age of debt the following percentages were derived. The percentage applied to injury cost recovery is that recommended by the DHSC.

Category of Debtor	Current Debt	1 to 30 Days Overdue	31 to 60 Days Overdue	61 to 90 Days Overdue	91 to 120 Days Overdue	121 to 180 Days Overdue	181 to 360 Days Overdue	361 + Days Overdue
Non Reciprocal Agreement - Overseas Visitor Debt	100%	100%	100%	100%	100%	100%	100%	100%
Staff Debt	10%	10%	15%	15%	25%	33%	50%	75%
Injury Costs Recovery (constant % as considerable time for payment to be agreed)	21.8%	21.8%	21.8%	21.8%	21.8%	21.8%	21.8%	21.8%
All Other Non NHS Debt	15%	15%	25%	25%	33%	50%	75%	100%

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

Derecognition

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

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

Note 1.12 Leases

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

The trust as a lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

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

Leases of land and buildings

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

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.15 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.16 Value added tax

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

Note 1.17 Corporation tax
The Trust has determined that it is has no corporation tax liability on the basis that it is solely a public sector body with no limited company subsidiary arm.

Note 1.18 Third party assets

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

Note 1.19 Losses and special payments

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

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

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. 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 2022, 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 defined by HM Treasury. Currently this rate is 0.91% 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. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 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 Trust has not adopted any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector.

Note 1.22 Critical judgements in applying accounting policies

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In accordance with note 1.7 and note 17, the Trust's land and buildings have been subject to a desktop review by the Valuation Office Agency in March 2021. The valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, leads to revaluation adjustments as described in 1.7 to the accounts. Future revaluations of the Trust's property may result in further changes to the carrying values of non-current assets.

No fundamental uncertainty as a result of covid-19 was included in the valuation report by the District Valuer.

Note 1.23 Sources of estimation uncertainty

There are no material uncertainties effecting any of the valuations shown in the Trust's 2020/21 accounts.

Note 2 Operating Segments

The Trust has no operating segments.

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Block contract / system envelope income*	332,516	322,579
High cost drugs income from commissioners (excluding pass-through costs)	130	-
Other NHS clinical income*	205	124
All services		
Private patient income	341	275
Additional pension contribution central funding**	9,713	8,663
Other clinical income from mandatory services***	5,824	10,384
Total income from activities	**348,729**	**342,225**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. [Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year. In 2019/20 £322,579k was seperated into seven different lines and is now aggregated.]

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

*** 2019/20 other clinical income from mandatory services included £3,268k for lost income resulting from Covid 19 effects in March 2020. This has been replaced by block contract income in 2020/21 and shown in the main block contract / systems envelope line in 2020/21.

Note 3.2 Income from patient care activities (by source)	2020/21 £000	2019/20 £000
Income from patient care activities received from:		
NHS England	41,304	39,683
Clinical commissioning groups	299,046	293,849
Other NHS providers	970	982
NHS other	705	711
Non-NHS: private patients	341	275
Non-NHS: overseas patients (chargeable to patient)	216	608
Injury cost recovery scheme	395	537
Non NHS: other****	5,752	5,580
Total income from activities	**348,729**	**342,225**
Of which:		
Related to continuing operations	348,729	342,225

**** includes £5,656k from Brighton & Hove Integrated Care Service (MSK services).

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

	2020/21	2019/20
	£000	£000
Income recognised this year	216	608
Cash payments received in-year	102	281
receivables	199	140
Amounts written off in-year	421	246

Overseas patient income included within this note of £216k for 2020/21 (£608k in 2019/20) only relates to overseas patients who do not come under the UK's reciprocal arrangement for the provision of healthcare. Overseas patients that are covered by the UK's reciprocal arrangement are invoiced to NHS West Sussex CCG, and is instead categorised as income from Clinical Commissioning Groups. In 2020/21 this income formed part of the overall block funding. Income covered by reciprocal arrangements amounted to £830k in 2019/20.

Note 4 Other operating income

	2020/21			2019/20		
	Contract Income	Non-contract Income	Total	Contract Income	Non-contract Income	Total
	£000	£000	£000	£000	£000	£000
Research and development	746	-	746	693	-	693
Education and training	7,964	476	8,440	7,046	261	7,307
Non-patient care services to other bodies	3,889		3,889	4,175		4,175
Provider sustainability fund (2019/20 only)			-	4,655		4,655
Marginal rate emergency tariff funding (2019/20 only)			-	5,181		5,181
Reimbursement and top up funding	23,520		23,520			-
gross basis	1,746		1,746	1,740		1,740
Receipt of capital grants and donations*		883	883		153	153
Equipment		6,756	6,756		-	-
Rental revenue from operating leases		47	47		48	48
Other income**	188	-	188	6,302	-	6,302
Total other operating income	38,053	8,162	46,215	29,792	462	30,254
Of which:						
Related to continuing operations			46,215			30,254

* Includes £747k representing the value of capitalised equipment provided to the Trust by DHSC to support the care given to patients with Covid.

** Other contract income relates mainly to income generation activities and was significantly impacted by covid in 2020/21.

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	2,320	2,167

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2021	31 March 2020
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	1,525	-
after one year, not later than five years	-	2,818
after five years	116	-
Total revenue allocated to remaining performance obligations	**1,641**	**2,818**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6.1 Operating expenses

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	2,712	3,064
Purchase of healthcare from non-NHS and non-DHSC bodies	6,608	7,800
Staff and executive directors costs	262,383	238,427
Remuneration of non-executive directors	92	93
Supplies and services - clinical (excluding drugs costs)*	35,345	30,317
Supplies and services - general **	5,286	5,319
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	23,280	24,836
Consultancy costs	62	26
Establishment	5,413	6,393
Premises	17,653	15,750
Transport (including patient travel)	642	557
Depreciation on property, plant and equipment	9,911	9,663
Amortisation on intangible assets	696	646
Net impairments	2,176	-
Movement in credit loss allowance: contract receivables / contract assets	(132)	299
Increase/(decrease) in other provisions***	1,655	-
Change in provisions discount rate(s)	188	92
Audit fees payable to the external auditor		
audit services- statutory audit	107	84
Internal audit costs	118	117
Clinical negligence	11,039	10,355
Legal fees	403	528
Insurance	225	188
Research and development	768	676
Education and training	2,548	2,520
Rentals under operating leases	44	50
Car parking & security	540	239
Hospitality	144	31
Losses, ex gratia & special payments	440	378
Other services, e.g. external payroll	522	319
Total	**390,868**	**358,767**
Of which:		
Related to continuing operations	390,868	358,767

*includes £6,650k in respect of utilisation of consumables (personal protective equipment) donated by DHSC.

** Includes £105k in respect of donated equipment for COVID response below the capitalisation threshold, donated by DHSC

*** Includes £1,548k in respect of redundancies associated with the Trust's decisions to terminate the Pathology Joint Venture with Brighton & Sussex University Hospitals NHS Trust.

Note 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,176	-
Total net impairments charged to operating surplus / deficit	2,176	-
Impairments charged to the revaluation reserve	178	-
Total net impairments	2,354	-

The £2,176k impairment shown above results from the difference in the market value and the Net Book Value of the following buildings:

	£'000
Neonatal Unit	1,766
Dental & Aldrich Blake Unit	79
Smallfiled Ward	300
Titan Building	31
	2,176

The £2,176k impairment charged against the Trust's operating surplus reflect the District Valuer valuing the above newly constructed/enhanced areas at less than their recorded book value (which includes the additional capital costs incurred). Book value impairments of this type are quite normal when hospital buildings are newly constructed or enhanced and purely reflect a reduction in the recorded Net Book Value of the buildings. There has been no physical or operational impairment to these buildings.

The £178k impairment reflects the fact the District Valuer has valued a number of areas at less then their previous book value (including capital enhancements). This mainly relates to the recently refurbished Geriatric Wards.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	203,162	179,717
Social security costs	20,947	18,680
Apprenticeship levy	967	882
Employer's contributions to NHS pensions	31,919	29,231
Temporary staff (including agency)	10,381	14,757
Total gross staff costs	**267,376**	**243,267**
Recoveries in respect of seconded staff	(2,570)	(2,740)
Total staff costs	**264,806**	**240,527**
Of which		
Costs capitalised as part of assets	324	240

Note 8.1 Retirements due to ill-health

During 2020/21 there was 1 early retirement from the trust agreed on the grounds of ill-health (none in 2019/20). The estimated additional pension liabilities of these ill-health retirements is £39k (£0k in 2019/20).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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 at 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.

The Trust also offers an additional defined contribution workplace pension scheme under the National Employment Savings Scheme (NEST). Under a defined contribution plan, the Trust pays fixed contributions into a fund, but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore effectively limited to the amount it agrees to contribute to the fund and effectively places actuarial and investment risk on the employee.

The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Contributions to a defined contribution plan which are not expected to be wholly settled within 12 months after the end of the annual reporting period in which the employee renders the related service are discounted to their present value."

Note 10 Operating leases

Note 10.1 Surrey and Sussex Healthcare NHS Trust as a lessor

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

The Trust granted a site lease to A2 Housing Solutions Ltd during 2008-09, for a term of 35 years from the date of completion. A2 replaced the old and poorly repaired staff accommodation (Canada House) with new build and refurbished modern key worker accommodation.

A2 Housing pays annual ground rent to the Trust over the duration of the lease term. This was at an initial amount of £35k per annum and is indexed annually. The 2020-21 charge was £47k. On termination of the lease, the land and buildings will revert back to the Trust.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	47	48
Total	**47**	**48**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	47	48
- later than one year and not later than five years;	187	192
- later than five years.	843	719
Total	**1,077**	**959**

Note 10.2 Surrey and Sussex Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Surrey and Sussex Healthcare NHS Trust is the lessee.

The operating lease payments and obligations shown below relate to motor vehicles leased by the Trust to transport staff and materials around the Trust various sites.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	44	50
Total	**44**	**50**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	38	51
- later than one year and not later than five years;	8	17
Total	**46**	**68**

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	6	160
Total finance income	**6**	**160**

Note 12 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	197	338
Finance leases	119	107
Total interest expense	**316**	**445**
Unwinding of discount on provisions	(10)	2
Total finance costs	**306**	**447**

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Losses on disposal of assets	-	(437)
Total gains / (losses) on disposal of assets	**-**	**(437)**
Total other gains / (losses)	**-**	**(437)**

The 2019/20 £437k loss on disposal of assets relates to 2 MRI scanners that had a net book value of £637K. One of these scanners, with a net book value of £457k, was transferred to the MRI service provider for £200k. This company, with effect from 1 January 2020, has been awarded a 15 year contract to perform MRI services for the Trust. The second MRI scanner, whose net book value was £180k, was considered to be beyond economic repair and has been disposed of by the Trust.

Note 14.1 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Gross cost at 1 April 2020	9,057	4	9,061
Additions	3,946	-	3,946
Reclassifications	4	(4)	-
Gross cost at 31 March 2021	13,007	-	13,007
Amortisation at 1 April 2020	7,199	-	7,199
Provided during the year	696	-	696
Amortisation at 31 March 2021	7,895	-	7,895
Net book value at 31 March 2021	5,112	-	5,112
Net book value at 1 April 2020	1,858	4	1,862

Note 14.2 Intangible assets - 2019/20

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Gross cost at 1 April 2019	8,505	-	8,505
Additions	552	4	556
Gross cost at 31 March 2020	9,057	4	9,061
Amortisation at 1 April 2019	6,553	-	6,553
Provided during the year	646	-	646
Amortisation at 31 March 2020	7,199	-	7,199
Net book value at 31 March 2020	1,858	4	1,862
Net book value at 1 April 2019	1,952	-	1,952

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020	12,760	154,956	9,023	37,558	15,431	4,307	234,036
Additions	-	1,990	3,679	10,410	2,713	295	19,087
Impairments	-	(1,227)	-	-	-	-	(1,227)
Reversals of impairments	12	1,037	-	-	-	-	1,049
Revaluations	(2)	(6,583)	-	-	-	-	(6,585)
Reclassifications	-	8,470	(9,523)	788	71	194	-
Disposals / derecognition	-	-	-	(727)	(1,450)	(353)	(2,530)
Valuation / gross cost at 31 March 2021	12,770	158,643	3,179	48,029	16,765	4,443	243,829
Accumulated depreciation at 1 April 2020	-	260	-	21,135	11,336	2,913	35,644
Provided during the year	-	4,931	-	3,108	1,532	340	9,911
Impairments	-	2,176	-	-	-	-	2,176
Revaluations	-	(6,835)	-	-	-	-	(6,835)
Disposals / derecognition	-	-	-	(727)	(1,450)	(353)	(2,530)
Accumulated depreciation at 31 March 2021	-	527	-	23,521	11,418	2,900	38,366
Net book value at 31 March 2021	12,770	158,116	3,179	24,508	5,347	1,543	205,463
Net book value at 1 April 2020	12,760	154,696	9,023	16,423	4,095	1,394	198,391

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	12,760	162,550	3,119	36,561	14,682	3,796	223,368
Additions	-	1,443	8,955	2,472	849	511	14,230
Revaluations	-	(1,772)	-	-	-	-	(1,772)
Reclassifications	-	2,735	(3,051)	316	-	-	-
Disposals / derecognition	-	-	-	(1,791)	-	-	(1,791)
Valuation / Gross cost at 31 March 2020	12,760	164,956	9,023	37,558	15,431	4,307	234,036
Accumulated depreciation at 1 April 2019	-	201	-	19,157	9,704	2,602	31,664
Provided during the year	-	4,588	-	3,132	1,632	311	9,663
Revaluations	-	(4,529)	-	-	-	-	(4,529)
Disposals / derecognition	-	-	-	(1,154)	-	-	(1,154)
Accumulated depreciation at 31 March 2020	-	260	-	21,135	11,336	2,913	35,644
Net book value at 31 March 2020	12,760	164,696	9,023	16,423	4,095	1,394	198,391
Net book value at 1 April 2019	12,760	162,349	3,119	17,404	4,978	1,194	191,704

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	12,770	155,774	3,179	21,789	5,334	1,495	**200,341**
Finance leased	-	1,148	-	1,446	-	-	**2,594**
Owned - donated/granted	-	1,194	-	1,273	13	48	**2,528**
NBV total at 31 March 2021	**12,770**	**158,116**	**3,179**	**24,508**	**5,347**	**1,543**	**205,463**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020							
Owned - purchased	12,760	152,215	9,023	13,943	4,071	1,390	**193,402**
Finance leased	-	1,207	-	1,862	-	-	**3,069**
Owned - donated/granted	-	1,274	-	618	24	4	**1,920**
NBV total at 31 March 2020	**12,760**	**154,696**	**9,023**	**16,423**	**4,095**	**1,394**	**198,391**

Note 16 Donations of property, plant and equipment

Donations for plant and machinery and IT were received by the Trust primarily from The Friends of East Surrey Hospital. These donations amounted to £136k in 2020/21 (2019/20 was £197k).

The Trust also received £747k of medical equipment from the DHSC, to manage the Covid pandemic. The DHSC require this transfer to recorded as a donated asset as no payment is expected from the Trust to the DHSC for this equipment. There was no equivalent transaction in 2019/20.

Note 17 Revaluations of property, plant and equipment

A full revaluation of the Trust site was carried out as at 31 March 2018 by DVS Property Specialists for the Public Sector, RICS qualified. The 2018/19, 2019/20 and 2020/21 valuations were prepared by the District Valuer as a desktop valuation. The basis of valuation required from 1 April 2015 is current value in existing use, as defined in the GAM and reflecting the adaptation approved by FRAB to IAS 16. Current value has regard to the service potential that an asset provides in support of the Trust's service delivery. The measurement approaches used to arrive at the current value of in use assets are Existing Use Value (EUV) as defined at UKVS 1.3 for non-specialised assets and Depreciated Replacement Cost (DRC) in accordance with UKVS 1.15 and UKGN 2 for specialised assets.

The District Valuer confirmed that where depreciated replacement cost (DRC) is used, the modern equivalent asset (MEA) principle has been applied.

The book value of other assets is deemed to be at fair value.

Note 18 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	944	1,014
Consumables	3,690	3,627
Total inventories	**4,634**	**4,641**

Inventories recognised in expenses for the year were £47,179k (2019/20: £34,067k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £6,650k of items purchased by DHSC. £6,280k of these were recognised as expenses in the year, resulting in £370k inventories at the 31st March 2021.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 19.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	8,116	17,765
Allowance for impaired contract receivables / assets	(2,179)	(2,345)
Prepayments (non-PFI)	2,679	2,012
PDC dividend receivable	659	126
VAT receivable	677	790
Other receivables	445	342
Total current receivables	**10,397**	**18,690**
Non-current		
Deposits and advances	11	11
Prepayments (non-PFI)	391	494
Finance lease receivables	3,872	3,872
Other receivables*	927	789
Total non-current receivables	**5,201**	**5,166**
Of which receivable from NHS and DHSC group bodies:		
Current	4,459	9,941
Non-current	927	789

*The £927k Non-Current "other receivables" is matched against £927k shown in the Trust Provisions (Note 33.1). This accounting entry relates to tax charge associated with Clinicians pensionable benefits. Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in 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). NHS providers organisations are required to create 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.

Note 19.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April 2020	**2,345**	-	**2,296**	-
New allowances arising	488	-	704	-
Changes in existing allowances	380	-	77	-
Reversals of allowances	(1,000)	-	(482)	-
Utilisation of allowances (write offs)	(34)	-	(250)	-
Allowances as at 31 March 2021	**2,179**	-	**2,345**	-

Category of Debtor:	2020/21	2019/20
	£'000	**£'000**
Non Reciprocal Agreement - Overseas Visitor Debt	1,007	1,304
Staff Debt	221	232
Injury Cost Recovery (constant % as considerable time for payment to be agreed)	203	251
All Other Debt	748	558
Total Credit Loss Provision	**2,179**	**2,345**

Note 20.1 Cash and cash equivalents movements

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

	2020/21	2019/20
	£000	£000
At 1 April	**16,541**	**10,145**
Net change in year	20,423	6,396
At 31 March	**36,964**	**16,541**
Broken down into:		
Cash at commercial banks and in hand	3	3
Cash with the Government Banking Service	36,961	16,538
Total cash and cash equivalents as in SoFP	**36,964**	**16,541**
Total cash and cash equivalents as in SoCF	**36,964**	**16,541**

Note 20.2 Third party assets held by the trust

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

Note 21.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	11,784	9,277
Capital payables	4,735	3,434
Accruals	20,587	12,389
Social security costs	2,968	2,737
Other taxes payable	2,713	2,317
Other payables	412	356
Total current trade and other payables	**43,199**	**30,510**
Non-current		
Other payables	2,883	2,993
Total non-current trade and other payables	**2,883**	**2,993**
Of which payables from NHS and DHSC group bodies:		
Current	4,241	4,837
Non-current	-	-

Note 21.2 Early retirements in NHS payables above

Nil 2020/21 (Nil 2019/20)

Note 22 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	1,641	2,818
Total other current liabilities	**1,641**	**2,818**

The block contract in 2020/21 eliminated the need to have deferred income for the maternity pathway in 2020/21, resulting in the reduction between years.

Note 23.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	1,113	1,349
Obligations under finance leases	540	600
Total current borrowings	**1,653**	**1,949**
Non-current		
Loans from DHSC	5,028	6,124
Obligations under finance leases	2,178	2,476
Total non-current borrowings	**7,206**	**8,600**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	**7,473**	**3,076**	**10,549**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,319)	(358)	**(1,677)**
Financing cash flows - payments of interest	(210)	(119)	**(329)**
Non-cash movements:			
Application of effective interest rate	197	119	**316**
Carrying value at 31 March 2021	**6,141**	**2,718**	**8,859**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2019	**17,835**	**3,383**	**21,218**
Cash movements:			
Financing cash flows - payments and receipts of principal	(10,362)	(765)	**(11,127)**
Financing cash flows - payments of interest	(338)	(107)	**(445)**
Non-cash movements:			
Additions	-	458	**458**
Application of effective interest rate	338	107	**445**
Carrying value at 31 March 2020	**7,473**	**3,076**	**10,549**

Note 24 Finance leases

Note 24.1 Surrey and Sussex Healthcare NHS Trust as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

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

	31 March 2021 £000	31 March 2020 £000
Gross lease receivables	**3,872**	**3,872**
of which those receivable:		
- later than five years.	3,872	3,872
Net lease receivables	**3,872**	**3,872**
of which those receivable:		
- later than five years.	3,872	3,872

Note 24.2 Surrey and Sussex Healthcare NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**2,937**	**3,076**
of which liabilities are due:		
- not later than one year;	540	600
- later than one year and not later than five years;	1,754	1,821
- later than five years.	643	655
Net lease liabilities	**2,718**	**3,076**
of which payable:		
- not later than one year;	540	600
- later than one year and not later than five years;	1,572	1,821
- later than five years.	606	655

There are no subleases in respect to the above leases.

No contingent rent has been recognised as expense in the period.

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	**1,479**	**449**	**120**	**-**	**789**	**2,837**
Change in the discount rate	36	14	-	-	138	188
Arising during the year	106	8	-	1,548	-	1,662
Utilised during the year	(149)	(33)	(83)	-	-	(265)
Reversed unused	(7)	-	-	-	-	(7)
Unwinding of discount	(8)	(2)	-	-	-	(10)
At 31 March 2021	**1,457**	**436**	**37**	**1,548**	**927**	**4,405**
Expected timing of cash flows:						
- not later than one year;	149	33	37	1,548	-	1,767
- later than one year and not later than five years;	592	132	-	-	927	1,651
- later than five years.	716	271	-	-	-	987
Total	**1,457**	**436**	**37**	**1,548**	**927**	**4,405**

Early Departure costs includes early retirements and injury benefits payable to former staff. Pension provisions have been calculated using figures provided by the NHS Pensions Agency which assumes certain life expectancies. Whilst this provides a degree of uncertainty in respect of both timing and total amounts, these estimates are based upon best available actuarial information. These costs are borne by the Trust and the Trust won't be reimbursed for them.

Legal claims are claims brought against the Trust by third parties. An annual adjustment is made to this provision based on the value of the member provision at the year end provided by NHS Resolution. The provision shown is the element of the claim (the excess value) that the Trust won't be reimbursed for.

The Trust Board approved a business case in January 2021 to join the Berkshire and Surrey Pathology Services. The Board approved the case after adaptation for the contents of an addendum (presented at the same time) which included a revised forecast for the redundancy cost at £1.5m. The Trust is now implementing the integration with BSPS and, having confirmed commercial arrangements with the BSPS Board (which affirmed no alternative source of funding), the Trust must provide for these costs.

The "other" provision relates to additional Pension costs associated with reimbursing clinicians for additional tax arising from their NHS pensions. This provision amounted to £927k as at 31st March 2021 (£789k 2019/20) and will be fully reimbursed in due course by the DHSC.

Note 25.2 Clinical negligence liabilities

At 31 March 2021, £176,116k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Surrey and Sussex Healthcare NHS Trust (31 March 2020: £167,367k).

Note 26 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
Employment tribunal and other employee related litigation	(351)	(94)
Other	(23)	(30)
Gross value of contingent liabilities	**(374)**	**(124)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(374)**	**(124)**
Net value of contingent assets	**-**	**-**

Note 27 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	2,529	2,005
Total	**2,529**	**2,005**

Note 28 Financial instruments

Note 28.1 Financial risk management

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

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

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

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

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

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

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	8,567	-	-	8,567
Cash and cash equivalents	36,964	-	-	36,964
Total at 31 March 2021	**45,531**	-	-	**45,531**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	16,413	-	-	16,413
Cash and cash equivalents	16,541	-	-	16,541
Total at 31 March 2020	**32,954**	-	-	**32,954**

No Financial assets have been reclassified between measurement categories, other than on implementation of IFRS 9 (IFRS 7 paragraph 12A to 12D),
No Financial assets and liabilities have been offset (IFRS 7, paragraphs 13A to 13F)
No Financial assets have been pledged as collateral (IFRS 7, paragraphs 14 and 15)

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	6,141	-	6,141
Obligations under finance leases	2,718	-	2,718
Trade and other payables excluding non financial liabilities	36,130	-	36,130
Total at 31 March 2021	**44,989**	-	**44,989**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	7,473	-	7,473
Obligations under finance leases	3,076	-	3,076
Trade and other payables excluding non financial liabilities	25,944	-	25,944
Total at 31 March 2020	**36,493**	-	**36,493**

There have been no defaults on loans payable or breaches of loan terms in the period (IFRS 7, paragraphs 18 and 19)

Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020
	£000	£000
In one year or less	37,938	27,887
In more than one year but not more than five years	5,922	6,968
In more than five years	2,155	1,638
Total	**46,015**	**36,493**

Note 28.5 Fair values of financial assets and liabilities

Book value is deemed to be a reasonable approximation of fair value and so have been used.

Note 29 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	34	43	29	12
Fruitless payments and constructive losses	-	-	14	9
Bad debts and claims abandoned	195	468	107	256
Stores losses and damage to property	29	66	19	64
Total losses	**258**	**577**	**169**	**341**
Special payments				
Compensation under court order or legally binding arbitration award	6	17	13	59
Ex-gratia payments	14	5	19	109
Total special payments	**20**	**22**	**32**	**168**
Total losses and special payments	**278**	**599**	**201**	**509**

There were no cases exceeding £300k in either 2020/21 or 2019/20.

Note 30 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Surrey and Sussex Healthcare NHS Trust.

The Department of Health and Social Care is the parent department for Surrey and Sussex Healthcare NHS Trust and is therefore a related party. During the year Surrey and Sussex Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is also regarded as the parent Department as detailed below:

	2020/21				2019/20			
	Income	Expenditure	Receivables	Payables	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000	£000	£000	£000	£000
Crawley CCG	0	0	0	0	78,935	0	358	453
East Surrey CCG	0	0	0	0	118,096	0	925	787
Horsham & Mid Sussex CCG	0	0	0	0	57,619	0	0	355
Surrey Downs CCG	0	0	0	0	21,397	0	1,313	84
Coastal West Sussex CCG	0	0	0	0	3,484	0	170	69
Croydon CCG	0	0	0	0	6,455	0	0	108
East Sussex CCG	1,730	0	0	0	0	0	0	0
Kent and Medway CCG	1,308	0	7	0	0	0	0	0
South West London CCG	7,504	0	1	0	0	0	0	0
Surrey Heartlands CCG	158,998	87	0	721	0	0	0	0
West Sussex CCG	142,161	0	0	136	0	0	0	0
NHS England	41,727	18	411	258	40,909	20	3,822	52
Health Education England	8,166	13	2,497	511	7,584	3	203	169
NHS Business Services Authority	765	6	23	0	711	0	64	0
NHS Resolution	0	11,232	0	0	7	10,501	7	0
NHS Property Services	0	2,824	0	1,698	128	3,281	0	1,112
Royal Surrey County NHS Foundation Trust	2,278	1,048	219	348	1,349	952	623	898
Sussex Community NHS Foundation Trust	678	924	148	380	885	1,030	208	341
NHS Blood & Transport	16	1,218	0	9	0	961	76	0

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies as detailed below:

	2020/21				2019/20			
	Income	Expenditure	Receivables	Payables	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000	£000	£000	£000	£000
NHS Pension Scheme	0	31,919	0	0	0	29,231	0	2,896
HM Revenue & Customs	0	21,914	0	21,914	0	19,562	0	5,054
Reigate & Banstead Borough Council	0	0	0	0	0	1,286	0	0

The Trust has also received revenue and capital payments from a number of charitable funds including the SASH Charity, certain of the Trustees for which are also members of the Trust board. The Trust received £170k from SASH Charity in 2020/21 and £58k in 2019/20. The Trust received £54k from the League of Friends in 2020-21, and £197k in 2019/20.

Note 31 Events after the reporting date

There have not been any material events after the reporting period.

Note 32 Better Payment Practice code

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	58,320	106,050	77,162	119,730
Total non-NHS trade invoices paid within target	56,498	101,970	74,224	114,997
Percentage of non-NHS trade invoices paid within target	96.9%	96.2%	96.2%	96.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,025	8,104	2,631	9,383
Total NHS trade invoices paid within target	1,914	8,482	2,425	8,990
Percentage of NHS trade invoices paid within target	94.5%	93.2%	92.2%	95.8%

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

Note 33 External financing limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(9,876)	(13,205)
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**(9,876)**	**(13,205)**
External financing limit (EFL)	17,402	(226)
Under spend against EFL	**27,278**	**12,979**

Note 34 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	23,033	14,786
Less: Disposals	-	(637)
Less: Donated and granted capital additions	(883)	(153)
Charge against Capital Resource Limit	**22,150**	**13,996**
Capital Resource Limit	23,174	14,885
Under spend against CRL	**1,024**	**889**

Note 35 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus (control total basis)	47
Breakeven duty financial performance surplus	**47**

Note 36 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		7,755	675	(6,056)	254	298	(2,374)
Breakeven duty cumulative position	(47,098)	(39,343)	(38,468)	(44,524)	(44,270)	(43,972)	(46,346)
Operating income		194,896	196,030	209,582	226,016	231,702	244,007
Income		(20.2%)	(19.6%)	(21.2%)	(19.6%)	(19.0%)	(19.0%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(6,531)	3,672	13,641	11,203	7,513	47
Breakeven duty cumulative position	(52,877)	(49,205)	(35,564)	(24,361)	(16,848)	(16,801)
Operating income	264,879	280,335	316,421	336,199	372,479	394,944
Income	(20.0%)	(17.2%)	(11.3%)	(7.2%)	(4.5%)	(4.3%)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

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