Together we care

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

ANNUAL REPORT and ACCOUNTS

1 April 2020 to 31 March 2021

Ashford and St. Peter’s Hospitals NHS Foundation Trust

Annual Report and Accounts 2020-21

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

Contents

Please note that some of the images used in our Annual Report and Accounts 2020/21 were taken prior to the COVID pandemic or before masks and social distancing were mandated.

1. INTRODUCTION

Welcome statement by the Chairman, Andy Field

Welcome to our Annual Report which covers the financial period from 1 April 2020 to 31 March 2021. In many ways, this has been an extraordinary and unprecedented year which has changed our lives and services in ways we previously could not have imagined.

A year during which the COVID pandemic, which has affected us all so deeply, brought unparalleled demand upon our services and which required our team to go continually well above and beyond for patients. I could not be more proud of the way in which team ASPH rose to this challenge, and of the ways in which they cared for patients and, importantly, for each other. Adding to this sense of pride, was the incredible generosity and continuing support given by the community we serve. I would like to extend my deepest and heartfelt thanks to the whole team and to the local community who have provided such exceptional and unwavering support.

During 2020/21, the team have worked both innovatively and at great pace to maintain important services whilst rapidly creating and providing additional capacity such as greatly expanded critical care services. Most importantly however, their overriding ambition has been to help keep patients safe. To do this, we have completely reviewed the way in which we operate, focusing closely on our new North Star Objective to prevent hospital acquired infection. We have also accelerated our work with system partners in the Surrey Heartlands Health and Care Partnership and the ongoing requirement for a collaborative system approach has never been more apparent than during the last year.

Despite these unprecedented challenges, the team have also continued to make significant progress against the delivery of large scale transformational projects some of which were already in train such as the roll out of an electronic patient record system in partnership with the Royal Surrey Hospital NHS Foundation Trust and others which arose from the emerging pandemic.

Some highlights from the year include:

- The build and mobilisation of several new theatres on the Ashford hospital site where we have created a dedicated elective site; this helps protect our patients via a 'green' COVID free pathway in terms of infection prevention and control. Ultimately this will also help ensure future resilience and the continuation of elective surgery during forthcoming periods of increased winter pressures;

- The rapid expansion of our ITU capacity from around 13 beds to 31 beds which enabled us to provide critical care to all who needed it, but also enabled us at the height of the pandemic to provide vital mutual aid to other acute trusts both neighbouring and as far afield as Kent;

- The creation of a new Endoscopy hub to ensure we have the essential capacity required within our locality;

- The rapid creation of a COVID vaccination hub, working with system partners and employing many people from our local community, to enable us to deliver 25,500 vaccines; a project which received positive acknowledgement from the Secretary of State who commented upon its clockwork precision;

- We completed the new multi-storey car park on the St. Peter's Hospital site, creating a modern facility which ensures a much improved experience for patients as well as for staff;

- We have commenced the long awaited build of the new Emergency Department and Priority Assessment Unit. Made possible through realising a significant financial surplus in 2018/19, this building will ensure we have the modern facilities and capacity to deliver the highest standards of care;

- We have modernised and extended our catering offer to staff and public, focussing on improved choice, healthy options and importantly upon ease of access for staff as part of our health and well-being programme.

Andy Field, *Chairman*

'We have seen extraordinary efforts and accomplishments in the face of unprecedented circumstances. The team and the community should feel immensely and justifiably proud. **#ItTakesaTeam**'

During 2020, Suzanne Rankin, Chief Executive was seconded firstly for a period of six weeks to investigate options for a local Nightingale hospital and secondly in June for a period of three months to NHS Test and Trace as the National Director for Containment. This was an important role and we were proud to see Suzanne bring her expertise to such an important national role. During this time Dr David Fluck, Medical Director was appointed as Acting Chief Executive and I would like to extend my thanks and appreciation to David for leading the organisation so capably during this period. My thanks also to Mr Faris Zakaria, who in turn stepped up as Acting Medical Director and who also later led the highly successful staff testing and vaccination programme.

I would also like to thank Dr Mike Baxter, who stepped down as Non-Executive Director in October 2020 to pursue other roles. We are grateful for the knowledge and expertise Mike brought to the Trust over many years, especially in his role as Chair of the People and Quality of Care

Committees. In his stead, we welcome Dr Dami Adedayo as Non-Executive Director. Dami was appointed in November 2020 and brings extensive expertise and is a current NHS General Practitioner.

I would also like to thank Yvonne Obuaya, who completed her one year term as an Associate Non-Executive Director in August 2020 as part of the NHS Improvement NExT Director Scheme. In her stead, I would like to welcome Dr Arun Thiyagarajan as our new Associate Non-Executive Director who joined us in November 2020. He is also a qualified doctor and is currently the Managing Director for BUPA UK's Health Clinics.

We continue to work collaboratively with our Council of Governors and I would like to take the opportunity to thank Cllr Maureen Attewell who served for five years as Appointed Governor from Spelthorne Borough Council and who stood down in 2020. We also welcome Cllr Rose Chandler as her replacement.

We also lost a much respected and highly valued member of the Council of Governors during 2021- Roberta Swan, who very sadly passed away in January 2021. She will be much missed.

Reflecting on this past year, we have been tested profoundly in so many ways: individually, collectively and as a Trust but we have risen to the challenge. However, we could not have done many of these things without the active and unwavering support we have received from the local community. This support has taken many forms from large scale programmes such as the essential grocery deliveries from the Nourish our Nurses charity, ably supported by volunteering visits from the Countess of Wessex and the Lord Lieutenant of Surrey, and significant donations of scrubs from the charity For the Love of Scrubs, though to PPE, treats and health and beauty product donations. We have also enjoyed a "first class lounge" service provided to the team by colleagues from British Airways, Virgin and Easyjet. However, we have also received cards and messages from local school children and an amazing groundswell of support from individual members of the community who showed their appreciation of the work that the team have done, the risks they have inevitably taken and the sacrifices they have made during the last twelve months.

I wish to extend a huge thank you, on behalf of the team, to everyone who has supported us here at the Trust - to the local businesses, the local schools, our local community, our volunteers, local faith groups and local charities. The support has been incredible and we are truly grateful, thank you.

In summary, I wish, once again, to recognise the incredible hard work of the ASPH team across the past year, a year which we will never forget but of which we should feel rightly proud. My heartfelt thanks to all my colleagues at Ashford and St. Peter's, and to our dedicated and much valued team of volunteers. Finally, I'd like to extend thanks for their support to all of our local partners: including commissioners, the ambulance service, local authorities, social care, primary care, community providers and mental health service colleagues; and to our members, the local voluntary sector and fundraisers all of whom support us so well.

Andy Field
Chairman

About us

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

Ashford and St. Peter's Hospitals NHS Foundation Trust serves a population of more than 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow, Surrey Heath and beyond. The Trust employs around 4,400 individual members of staff. Our turnover was £387.3 million in 2020/21.

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

Our catchment area

We've been busy

During the year we have:

TREATED
31,500
EMERGENCY ADMISSIONS

ADMITTED
28,176
PEOPLE FOR PLANNED INPATIENT AND DAY CASE TREATMENT

SEEN
88,656
PEOPLE IN OUR A&E DEPARTMENT

TREATED
41,042
PATIENTS IN OUR OUTPATIENT CLINICS

HELPED DELIVER
3,340
BABIES

HAD A TURNOVER OF
£387.3m

TREATED
204,373
THROUGH VIRTUAL CLINICS

ADMINISTERED
25,500
COVID VACCINATIONS

WE CARED FOR OVER
1700
COVID PATIENTS

Our services

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

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

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

Ashford Hospital

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

St. Peter's Hospital

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

Woking Community Hospital

- Inpatient Neuro-rehabilitation services
- Outpatient Services
- Physiotherapy

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

Our vision and strategy

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

Our vision

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

Our mission

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

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

'I was treated with compassion'

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

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

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

Our Strategic Objectives

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

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

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

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

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

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

Local context:

North West Surrey ICP Alliance

Along with partners across North West Surrey, the Trust has now signed the NWS Integrated Care Partnership Alliance. The NWS ICP Alliance is one of four local alliances within the Surrey Heartlands Integrated Care System (ICS) and is one of the largest public sector Alliances in the UK. It is taking a different approach to improving the health and wellbeing of the 370,000 people living across Elmbridge, Runnymede, Spelthorne and Woking.

By bringing together local health and care organisations, offering a wealth of expertise, the Alliance works to a single, shared set of goals to deliver excellent outcomes for local people, with a delegated budget and decision making to reduce duplication of effort and resources.

The individual organisations that form the Alliance are:

- Ashford and St. Peter's Hospitals NHS Foundation Trust
- Surrey County Council
- Spelthorne, Woking, Elmbridge and Runnymede Borough Councils
- NHS Surrey Heartlands Clinical Commissioning Group
- CSH Surrey
- Woking and Sam Beare Hospice
- North West Surrey Integrated Care Services

Despite much higher demand and complexity experienced from the second wave of the COVID pandemic, and staff who have been under pressure for an extended period of time, the system has shown continued resilience, managing the response in collaboration with partners with a strong level of stability and demonstrating tangible improvements and successes at the same time.

Immediate priorities going forward include:

- **Priority 1**: Looking after our people through effective decompression and effective long term support
- **Priority 2**: Restoring critical services
- **Priority 3**: Embedding Innovation including a sustained structure for vaccination and embedding digital models

Surrey Heartlands Integrated Care System (ICS)

Surrey Heartlands is one of 17 Integrated Care Systems (ICSs) working to improve health and care for the local population. Surrey Heartlands brings together the previous commissioning areas of Surrey Downs, North West Surrey, Guildford and Waverley and East Surrey. It was the second ICS in England behind Greater Manchester to achieve devolution, giving more local control on health spending and access to further transformational funding.

The Surrey Heartlands Integrated Care System aims to improve services and health outcomes for local people and to add value through working together. System partners take collective responsibility for improving health outcomes, managing resources and delivering NHS standards.

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

"This has been an extremely challenging year for health and public services across the country. Despite the on-going response to the COVID pandemic, NHS, local government and voluntary sector organisations across North West Surrey have come together to form a comprehensive formal partnership – the North West Surrey Health and Care Alliance. Ashford and St. Peter's has been a leading, founding partner and has continued to use the Trust's considerable expertise to drive a joined up approach to supporting people through the COVID crisis and shaping more integrated services as we recover and move forwards. Over the course of the year ASPH has worked across different settings to coordinating staff to keep services safe, rapidly adopting new technology and supporting developments in areas like accommodation for the most vulnerable. The Trust continues to be a real asset to our Alliance across North West Surrey."

Jack Wagstaff, North West Surrey ICP Director

National policy:

The NHS Long Term Plan, published in January 2019, sets out ambitions for ensuring the NHS is Fit for the Future and covers a ten year period The plan encompasses the following key principles:

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

In February 2021, the Department of Health and Social Care (DHSC) published a White Paper, "Integration and Innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill". This paper sets out the broad ranging proposals for altering the current legal framework to create integrated services, meet the challenges of the current and future pandemics and other known and unknown future challenges. The Trust is working in partnership at both a local and Surrey Heartlands level to achieve a sustained recovery from the COVID pandemic and to respond to the forthcoming changes in legislation.

2. PERFORMANCE REPORT

£387.3m
TURNOVER

£76.6m
CASH BALANCE

Performance Report - Overview

Statement by the Chief Executive

The last year has brought unprecedented challenges to the Trust in ways we could not have previously imagined. The COVID pandemic required us to swiftly and radically adapt the ways in which we provide services, including the rapid expansion of the critical care provision, the implementation of new infection prevention and control practices, creation of COVID safe pathways for patients throughout the Trust and the transformation of many established ways of working as well as the way we deliver care especially in outpatients and for those accessing planned care such as diagnostics and elective surgery. This has been made possible through the extraordinary efforts of Team ASPH who have demonstrated enormous resilience, compassion and professionalism alongside the incredible support of the local community and our partners.

Financially, we ended the year with a retained deficit of £3.7m, although after adjusting for allowable items including impairments, donated assets and stocks of centrally procured goods we broke-even in line with the annual plan set for us. Due to the COVID pandemic our turnover increased substantially to £387.3m from £343.4 million in 2019/20.

Our stable underlying financial position meant we continued to invest substantially in the much needed capital schemes, including in new theatres for Ashford, new wards at St Peters and the Surrey Safe Care programme. This also offers the opportunity for future developments to improve our facilities for the team and for patients. Overall, the Trust retained focus on delivery of the Together We Care Strategy and its strategic objectives (see the Strategic objective section on page 36 for more detailed analysis) and at the same time, defined a new North Star Objective to prevent the spread of hospital acquired infection. To underpin this new and essential objective, a new operating model was developed with infection prevention and control as the central guiding principle. This performance overview reveals some of the challenges of balancing the requirement to meet unparalleled demand for services, alongside the deployment of the new operating model in order to keep patients and staff safe. As we continue to strive towards the delivery of our strategy and towards outstanding experience and the best outcomes for patients and the team, one of the means by which we can understand the fulfilment of the strategy is through our performance.

The impact of the COVID pandemic and national lockdowns during 2020/21 created fluctuating attendances and considerable pressure on our emergency care pathways. Challenges regarding inpatient flow have continued to dominate and exacerbate our Capitalise Emergency Department (ED). However, despite these challenges the Trust's overall annual performance for the A&E four hour standard at 87.4%[1] remained above the average England performance of 86.9% for the year. To support an improvement in the Trust's ED performance, we have secured substantial capital investment to support a number of schemes over the coming year which will increase ED capacity, create a Priority Admissions Unit and increase flow through provision of dedicated assessment capacity and short stay units. The Trust received over 17,000 urgent cancer referrals during the year and provided full referral, diagnostic and treatment facilities for clinically urgent, risk assessed procedures for cancer patients during the COVID pandemic.

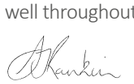
The Trust achieved annual compliance for cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen, including annual compliance for treatment within 62 days. The Trust's performance compares extremely well against the England national average performance for treatment within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

The impact of COVID and the requirement to prevent transmission of the virus created significant disruption for elective surgery and routine outpatients. The Trust had an improving Referral to Theatre (RTT) performance and was upper quartile nationally performance until the COVID pandemic; although then saw deterioration in performance during the first half of the year. Good improvement was seen during Q3 although this was impacted during the substantial surge received in COVID inpatients during Q4 and the requirement to once again pause most elective surgery. The Trust's annual RTT position was recorded at 77.1%, with improvement seen during Q4 to 79.2%. This level of performance, whilst falling lower than the national target of 92%, remains favourable against the average England performance of 61.7% for the year. The Trust has robust plans to improve RTT performance during 2021/22 ensuring patients are treated safely and in order of clinical priority and chronological order. Substantial improvement in reducing the number of patients waiting for surgery are scheduled whilst ensuring patients have their outpatient appointments and diagnostic tests as early as possible.

Whilst historically staffing has been one of our biggest challenges, the excellent progress we made during the latter part of 2019/20 continued throughout the year with significant reductions in agency spend and continued increases in the numbers of staff recruited into substantive posts. This was strengthened substantially by the number of people from within our local community who joined the Trust to help staff the COVID vaccination hub, some of whom have gone progressed into substantive roles.

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

During the course of the year we have continued to deliver against our transformation programme as well as the strategic objectives encompassed within our Together We Care Strategy. In particular, under the People objective, the physical and mental health well-being and resilience of the team has clearly been, and continues to be tested with the consequences a very real concern. We have deployed a range of well-being strategies and interventions to support Team ASPH in taking time to rest and recover following the first and second waves of the pandemic. We will continue to enhance and refine the well-being offering to the team and the recovery of their mental and physical resilience remains a significant priority in the face of the experience they have had, the current demands, the need for sustainability and potential for any future surge as well as the need once more to mobilise to meet the needs of the community we serve. Once again my thanks to the local community, volunteers, schools, churches, charities and individuals who have contributed so much and supported us so well throughout the past year for which we are all are immensely grateful.



Suzanne Rankin
Chief Executive

10 June 2021

[1]NHSI/E recorded definition including North West Surrey Footprint

Key issues and risks

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

Strategic Objective: Quality of care

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

Strategic Objective: Modern healthcare

2.1	Inability to live within the new financial framework envelopes (when announced) due to the likely requirements to run elective work during winter, undertake or outsource additional catch up activity, whilst reconfiguring / expanding bed, diagnostic and outpatient capacity, and given existing staffing constraints.
2.2	A failure to maintain the Trust's physical environment and clinical infrastructure, may lead to clinical pathway difficulties, deteriorating patient and staff experience, patient safety, and health and safety risks.
2.3	A failure to deliver constitutional and operational targets leading to increased patient delay, poor patient experience, increased patient safety risks, increased outsourcing or activity and corresponding loss in productivity / efficiency.
2.4	The myriad of changes to operational arrangements, supply/demand, social distancing requirements and increased staff absence from COVID may have substantial impacts on our previous productivity / efficiency and financial standing.
2.5	Potential external impacts from the Surrey Heartlands ICS overall financial, activity level, and waiting list positions as well as requirements for mutual aid.

Strategic Objective: Digital

3.1	ePR Programme: The Trust's service delivery may be compromised if the current strategy to exploit the electronic patient record fails.
3.2	Critical Systems Maintenance and Replacement: Failure of key IT systems could lead to issues of patient safety, experience or quality risks, or process delays.
3.3	Cyber security and data protection breaches could threaten the provision of IT systems, leading to issues of patient safety, experience or quality risks, or process delays.

Strategic Objective: People

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

Strategic Objective: Collaborate

5.1	Insufficient capability and capacity to deliver the strategy programme (i.e. the strategic objectives) in accordance with the operating plan so that effect is diminished and/or service sustainability is significantly challenged.
5.2	External factors such as decisions taken by national, ICS, ICP impact our delivery or attempt to counter our objectives or undermine our service sustainability.
5.3	Ineffective oversight of the strategy may result in the desired effect and intended benefits to quality and sustainability of patient care not being realised.
5.4	Ineffective or insufficient focus on stakeholder management may result in effective external relationships not being sustained.

For more detail on how we manage and respond to risk see our Annual Governance Statement on page 104.

Going concern disclosure

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

Performance Analysis

Detailed activity review

A&E Attendances

Overall the Trust saw a 20% reduction in A&E attendances, due to reduced numbers of patients attending through the first and second wave of the COVID pandemic.

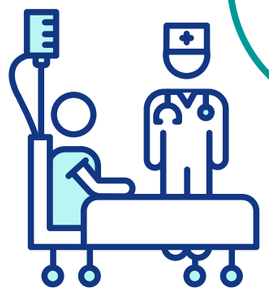
88,656

20% reduction

ASPH ITU Capacity

During the second wave of the pandemic, the Trust created a pop-up ITU and increased its existing ITU capacity to care for COVID positive patients and offer mutual aid across the system and wider.

Was tripled, 13 to 31 ITU beds



Day case procedures

The activity was significantly reduced due to the COVID pandemic.

24,182

DAY CASE PROCEDURES

-37%

Elective (planned) admissions

Activity was significantly reduced due to the need to respond to the pandemic.

3,994

ELECTIVE ADMISSIONS

-39%

Virtual

There was a huge increase in virtual clinic appointments - at the height of the pandemic these accounted for up to 80% of appointments.

204,373

+668%

Emergency admissions

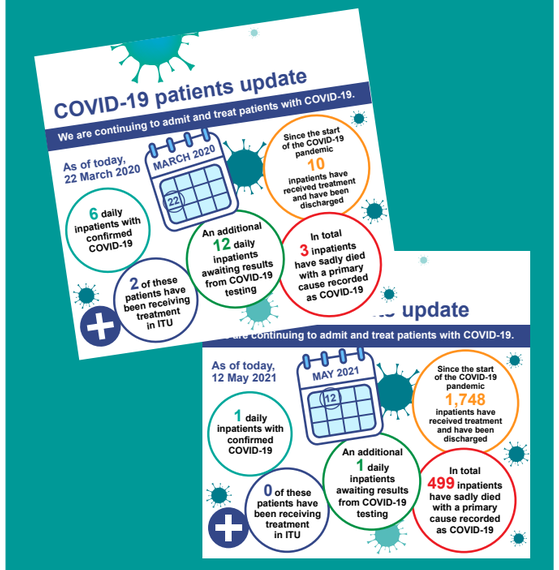
Emergency admissions slightly declined as less patients attended the hospital due to the COVID pandemic.

31,500

-6% reduction

COVID Patients

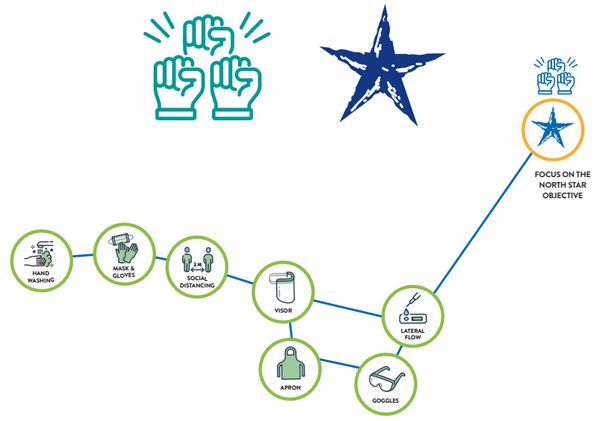
Since the start of the pandemic in March 2020, up until 31 March 2021, the Trust cared for over 1700 COVID patients.



Vaccinations

The Trust mobilised a COVID vaccination hub which administered vaccines to the ASPH team, healthcare workers from partner organisations and the public.

Administered 25,500 vaccinations



FOCUS ON THE NORTH STAR OBJECTIVE

No matter where you are or your job role within the organisation, we all need to work together, stay on course and learn from practice across the organisation and beyond.

Key performance metrics

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

National Targets and Minimum Standards	Target	Target (2020/21)	2020/21	2020/21				2019/20	2018/19	2017/18
				Q4	Q3	Q2	Q1			
Infection Control	Number of clostridium difficile cases	17	18	5	7	3	3	27	14	15
	Number of MRSA blood stream infection cases	0	2	2	0	0	0	2	0	1
Access to Cancer Services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	97.5%	97.3%	97.8%	97.3%	97.3%	97.1%	97.9%	98.5%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98%	98.2%	95.0%	100%	100%	97.4%	99.3%	100%	100%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	92.4%	100%	100%	78.9%	90.0%	78.0%	94.8%	96.9%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment	85%	88.0%	87.9%	87.6%	90.8%	84.7%	84.1%	85.8%	87.2%
	% of cancer patients waiting a maximum of 2 months from the consultant screening service referral to treatment	90%	85.7%	68.8%	96.3%	80.0%	88.2%	90.0%	92.1%	94.0%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	95.5%	95.8%	96.1%	93.6%	97.0%	93.7%	92.4%	93.2%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	96.7%	98.0%	96.4%	95.1%	97.4%	97.4%	97.2%	96.5%
Access to Treatment	18 weeks Referral to Treatment - patients on an incomplete pathway	92%	77.1%	80.5%	84.1%	70.5%	71.4%	92.0%	91.2%	92.0%
Access to A&E (SPH)	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge (St. Peter's site only)	95%	81.4%	75.3%	74.5%	86.0%	91.9%	76.4%	79.0%	85.1%
Access to A&E (NHSI)	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge NHSI: including Woking and Ashford	95%	87.4%	83.3%	83.0%	90.8%	94.3%	86.1%	88.4%	91.0%
Access to patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	n/a	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Our performance explained

Infection control – hospital acquired infections

There were 18 cases of Trust- apportioned Clostridiodes difficile infection recorded during 2021/22. This is a 33% decrease from the previous year. The rate per 100,000 bed days is 5.44 meaning this Trust had the 14th lowest (i.e. best) rate out of 145 Trusts in England.

There have been two Trust apportioned MRSA bacteraemias during 2020/21 (one in January 2021 and one in February). This is equal to the number of cases when compared to the previous year. Learning from Post Infection review of cases has highlighted the need to rescreen patients for MRSA prior to surgery in the event of their initial surgery being delayed, as well as ensuring all wounds are swabbed as part of routine MRSA screening. This Trust MRSA policy has been updated to reflect this requirement.

As a consequence of the robust infection prevention and control processes and pathways put in place to prevent the transmission of COVID, we also saw an extremely low number of nosocomial infections within the hospitals. The Trust sustained a position as one of the 10 lowest (i.e. best performing) Trusts in the country.

Access to Cancer Treatment

The Trust received over 17,000 urgent cancer referrals during the year, an overall 7.5% decrease compared to the previous year although a total 25% increase over the previous 3 year period. The Trust provided full referral, diagnostic and treatment facilities for clinically urgent, risk assessed procedures for cancer patients during the COVID pandemic and continues to work with our commissioners at Surrey Heartlands CCG to support delivery of compliant performance.

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

During the start of the COVID pandemic we experienced difficulties in meeting the 62 day standard for urgent GP referrals due to the complexity of ensuring patients and staff remained safe during a very uncertain time regarding transmissibility of the virus.

The Trust marginally missed the standard for meeting the 62 day standard for urgent GP referrals during Q1, although achieved compliant performance for the remainder of the year. Improving cancer waiting times is a continued area of focus and work is being undertaken with primary care in patient engagement, and ensuring the Trust, partner and tertiary providers have sufficient ongoing capacity to meet current and future demand to maintain and improve compliance.

The Trust undertakes multiple weekly PTL meetings to track and prioritise patients on cancer pathways to ensure patients diagnosis and treatments are expedited. In terms of monitoring performance, a weekly Cancer oversight meeting is held (chaired by the Deputy Chief Operating Officer) which specifically monitors cancer performance and progression of our cancer improvement plans, with monthly meetings also held with the Trust's lead commissioner.

Referral to Treatment (18 week target)

The impact of COVID and the risk of transmission and the redeployment of theatre staff to critical care, created significant disruption for elective surgery and routine outpatients. During the first wave of COVID during Q1, the Trust, similar to others, was asked by NHSE/I to halt elective surgery to ensure sufficient beds and staffing were available to care for the surge in COVID inpatients. During this time RTT and planned follow-up appointments continued where possible through use of telephone and virtual clinics, or face to face where required and available and safe to do so.

During Q2, the Trust recommenced elective surgery in a COVID secure manner through the support of a number of local Independent Providers, and substantial investment in the upgrade and enhancement of theatres and wards at our Ashford hospital site and facilities at community partners. This required significant patient pathway redesign and the introduction of substantial infection prevention control regimes to prevent transmission of infection.

However, to support the substantial surge received in COVID inpatients during Q4, theatre nurses and anaesthetists were again redeployed from theatres to support super surge ITU capacity, which resulted in most elective surgery being paused. Medical staff surge rotas were also implemented to support over 200 inpatient

COVID beds during this time by redeploying resource from a range of activities, which included the requirement to pause a number of outpatient clinics. Where medical, nursing or other staff were not required to support COVID surge activities, they continued in their substantive roles which allowed some of outpatient activity to continue along with diagnostic and all cancer cases.

The Trust had an improving RTT performance until the COVID pandemic; although then saw deterioration in performance during the first half of the year. Good improvement was seen during Q3 although this was impacted during the substantial surge received in COVID inpatients during Q4 and the requirement to pause most elective surgery.

The Trust has robust plans to improve RTT performance during 2021/22 ensuring patients are treated in clinical and chronological order. This will ensure an improvement in the number of patients waiting for surgery, outpatient appointments and diagnostic tests.

The Trust's annual RTT position was recorded at 77.1%, with improvement seen during Q4 to 79.2%. This level of performance, whilst falling lower than the national target of 92%, remains favourable against the average England performance of 61.7% for the year.

Furthermore, the Trust's performance as we emerge from the COVID pandemic, has placed a number of the Trust's specialties within the top 10 for RTT performance across England (with 10,000+ patients on their waiting list) including a comparatively low number of patients waiting over 52 weeks for treatment.

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

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

A&E four hour waiting target

Like many providers across England, the Trust remained challenged with the A&E four hour waiting target throughout the year recording a total of 87.4% (NHSI) for the full year and 94.3%, 90.8%, 83.0% and 83.3% respectively for the four quarters of the year.

The impact of the COVID pandemic and respective national lockdowns created highly fluctuating attendance levels on both a daily and monthly basis. To ensure patients and staff remained safe and to prevent transmission of the virus, the Trust created two physically separate pathways through the emergency department (one for COVID and one for non-COVID patients) albeit increasing pressure on an already compressed site.

Despite the above measures, the Trust recorded almost compliant performance during Q1 (First COVID wave) due to the reduced levels of ED attendance within the department and excellent flow into the wards due to low Trust bed occupancy at that time.

Since this time the Trust has seen varied performance levels mainly due to the high occupancy and restricted availability of Trust beds causing slow flow from ED to wards and restricted space within ED keeping separate 'COVID' and 'non COVID' patient flows.

Challenges regarding inpatient flow have continued to dominate and exacerbate our emergency department pressures through a lack of flow from the Emergency Department to inpatient wards.

The Trust has secured substantial capital investment to support a number of improvement schemes over the coming year which will;

- Increase ED capacity including extension of Same Day Emergency Care (SDEC) and Fit 2 Sit to permit safe segregation, including additional Point of Care testing
- Create a Priority Admissions Unit to increase footprint for patient monitoring and review, and
- Increase flow through provision of modular wards and additional assessment capacity and short stay. However, despite the challenges identified above the Trust's overall annual performance at 87.4% remained above the average England performance of 86.9% for the year.

A&E performance is monitored on multiple occasions during each day at regular Capacity Action Team (CAT) meetings with key hospital operational staff, and weekly Trust wide operational and breach review meetings to seek and implement improvement opportunities.

Equality of service delivery

Our overarching ambitions are to continually ensure the health needs of our diverse communities are better met and that health inequalities are reduced year on year. Also to demonstrate an improvement in patients' experiences of accessing and receiving care and services that take into account individual needs and preferences. We are currently developing detailed plans with key stakeholders around how to deliver this in the coming months.

Trust wide Assurance and Governance

From the commencement of the COVID pandemic, the Trust implemented the NHS Emergency Preparedness Resilience and Response Command structure ensuring a command and control structure was in place for the overall management of the event, formulating a strategy to respond to the incident and permitting staff to escalate concerns and seek advice and support.

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

The Trust also provided weekly and monthly performance updates to Surrey Heartlands ICS and meetings where appropriate to review all aspects of Trust performance, included recovery and future planning capacity during the pandemic and recovery planning phases to support the return to compliance.

Financial performance

2020/21 was an exceptional year where we faced a substantial upheaval to our financial and operating environment caused by the COVID pandemic.

We faced sustained operational, workforce and financial pressures, with two waves of COVID putting significant pressure on all our workforce and internal processes. Similar pressures also affected all our wider system partners leading to the need to coordinate our service provision at both a local system and regional level.

The year began with the start of the COVID pandemic which entailed reworking all of our services, expanding critical care and our respiratory provision, while curtailing other mainly elective services. We focussed heavily on preventing infection, accelerated the split of our elective pathways in Ashford from the non-elective pathways at St. Peter's and moved to virtual care pathways wherever possible. The consequences of this on our expenditure was significant with turnover increasing substantially to £387.3m in 2020/21 from £343.4m in 2019/20.

We embarked on a number of significant new investments intended to fundamentally redesign our offering to both the public and staff. We completed the new multi-deck car park, added a pop up ITU facility within Chestnut ward, and commenced work on the new ward block at St Peters. Our developments in Ashford focused on developing our elective capacity with a new main theatre and refurbishment of two existing theatres. We also leased temporary modular theatres and endoscopy units across both sites to accelerate our elective recovery trajectories. We also embarked on our Surrey Safe Care programme to roll out the Cerner electronic patient record in a single instance in partnership with the Royal Surrey Hospital.

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

	2020/21	2019/20
	Actual £m	Actual £m
Income		
Clinical Income	336.6	312.2
Non-Clinical Income	49.0	30.9
Total Income	**385.6**	**343.1**
Expenses		
Pay Costs	-240.7	-215.0
Non-Pay Costs	-129.4	-111.8
Total Expenses	**-370.1**	**-326.8**
EBITDA	15.5	16.3
Depreciation and Amortisation	-9.7	-8.8
Impairments, net of reversals	-5.3	-0.5
Charitable contributions	1.7	0.3
Interest (net)	-0.3	-
Dividend on PDC	-5.6	-6.1
Reported net (deficit)/surplus	**-3.7**	**1.2**
Items excluded from our performance against the regulatory control total:		
Less capital donations / donated asset depreciation	-1.4	-0.1
Add back net impairment costs	5.3	0.5
Less net impact of donated consumables	-0.2	-
Remove impact of prior year PSF post accounts reallocation	-	-0.5
Adjusted financial performance surplus/(deficit)	**0**	**1.1**

Key movements year on year are set out below:

- Total income increased by £42.5m (12.4%) year on year. This was a result of our income being rolled over by the NHS based on the peak winter months in 2019/20 together with a range of additional allocations to negate the impact of COVID on our historic income and expenditure.
- Pay costs were £25.7m (12%) higher than 2019/20, mainly driven by COVID and annual leave impacts. Within this though we saw positive impacts from an increase in our substantive headcount and reduction in temporary staffing costs (including agency).
- Non-pay costs were £17.6m (15.8%) higher than 2019/20. Material drivers of this included additional consumables (PPE) purchased nationally by the DHSC £6.2m, increased expenditure on premises of £5.6m, increased impairments on assets of £4.8m and Clinical Negligence Scheme for Trusts increased recharges of £2.6m.

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

The Trust's was not required to deliver a cost improvement programme (CIP) in 2020/21 due to the COVID pandemic.

The main elements of the 2020/21 capital programme of £41m included:

- The commencement of a new 62 bedded Priority Admission Unit £9.1m;
- Completion of the new multi-storey decked car park £9m;
- £3.7m of investments within the Ashford theatres;
- £3.6m towards setting up the Surrey Safe Care (electronic patient record);
- £1.7m investment in Chestnut Ward to form a pop-up ICU; and
- £1.4m on server resilience

The majority of the capital programme was funded from internally generated resources; however in addition the Trust (i) increased borrowings in the form of finance leases on our Imaging Managed Equipment Service, and (ii) received Public Dividend Capital allocations totalling £17m, £9m of which supported the Priority Admissions Unit above.

Cash balances were supported throughout the financial year by payments received in advance from our commissioners and £12.6m received in respect of previous year land sales. The Trust ended the financial year with an increased cash balance of £76.6m.

The finance score measurement by NHS Improvement forms part of the Finance and Use of Resources theme in the NHS Oversight Framework, and is scored between 1 and 4, where 1 is 'low risk'. As a result of the impact of the pandemic on NHS finances, NHS improvement temporarily suspended monitoring Trusts financial performance in terms of an overall finance score. As a result there is no finance score for 2020/21 (2019/20 – 2).

2021/22 Plan

As a result of the COVID pandemic the operational planning for 2021/22 was again deferred, and our revenue budgets were set in line with the block and top-up contract arrangements initiated by NHS England and NHS Improvement. As a result of these arrangements we are expect to deliver a surplus of £1.3m during the first half of 2021/22. Our capital programme continues with significant investments in the Priority Admissions Unit, the Emergency Department, the Surrey Safe Care project and on electrical resilience works.

Suzanne Rankin
Chief Executive

10 June 2021

Progress against our strategic objectives

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

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

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

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

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

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

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

Strategic objective 1: Quality of Care

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

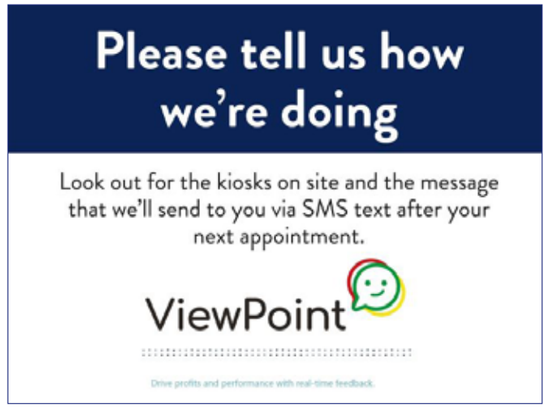
Our key achievements over the last year are:

Becoming a learning organisation

We continue to build on becoming a learning organisation by reflecting on situations to advance existing practices and improve our processes at the Trust.

We recently launched a new method of gathering real time patient feedback with the use of Viewpoint interactive kiosks which are assessable to patients and visitors across St. Peter's and Ashford Hospital sites. We have extended this project to include the use of SMS texting which enables all patients who have had appointments that have been virtual either online or by phone, to also give their valuable feedback by completing a short survey.

This new approach to service evaluation and the use of real time feedback will help us to greatly improve patient experience. It will aid us to respond and adapt our services; continuing to put patients at the centre of what we do here at ASPH.



We also run PeakOn - our staff, friends and family test, a real-time feedback tool that provides us with evidence to understand the bigger picture, improve the working experience of colleagues and the corresponding experience for patients.

Strengthening our approach to Harm-Free Care

The Harms Free Care Team is now embedded in the Trust with the development of the Trust Harms Free Care Strategy and were responsive in the prevention of hospital associated harms which were heightened due to COVID. The team also supported the roll out of the new ASPH Infection, Prevention and Control (IPC) Strategy created in the response to the pandemic, that innovatively and robustly looked to reduce COVID transmission and hospital acquired COVID infection as well as other infections too. This has been so effective the Trust had the 14th lowest rates of hospital acquired COVID, out of 145 Trusts across England.

Going forwards the team has robust plans for the reduction in hospital associated harms. One of the projects the Harms Free Care Team is working on is improving hydration with a pilot on one of the Senior Adult Medical Wards. Inadequate hydration contributes to the development of hospital associated harms and therefore is an overarching improvement aim for the team.

The new branding for patient discharge packs

Improving discharge processes

As a result of the COVID pandemic, we have been building upon work already conducted to improve discharge processes and to align with new discharge guidance published by the government. We have imbedded a new process collaborating with partners, patients and loved ones to prevent unnecessary hospital stays which helps to ensure that patients receive the right care, at the right place, at the right time, and are in the best possible position to continue their recovery when they are ready to leave an acute hospital setting.

As part of this project, we have developed a branded discharge pack that contains all the key information for patients about the discharge process which is given to them on admission. The pack ensures that patients are aware of their discharge plans, the process of leaving hospital and their expected discharge date. We have also made the information available on our website so that family members and carers can access it and familiarise themselves with the process.

Dealing with issues and complaints

From 1 April 2020 to 31 March 2021 we received 445 complaints and concerns and 2662 PALS contacts. This compares to 471 complaints and concerns and 1891 PALS contacts received during the previous year. The increase (40%) of PALS contacts is largely due to the challenges posed by COVID, including very restricted visiting, and many rearranged appointments, leading to an increase in the volume of people getting in touch with us in this way.

Complaints and concerns have remained steady in number but many of these have been longer and more complex as a result of COVID, and to ease pressures on clinical staff who are usually required to respond quickly to requests for information on complaints, the timeframe was extended to 35 days. On average we have responded to 84.8% of complaints within the agreed timeframe, between 1 April 2020 and 31 March 2021.

The Patient Panel has been relaunched recently with refreshed membership and the terms of reference have been reviewed, along with the direction of the committee. The intention is that the members will be involved in all divisions across the Trust, and can contribute to co-production work and planning.

ASPH contribution to Research and Development through the pandemic

At the beginning of the pandemic there were no known treatments and no vaccines but much progress has been made over the past year and we are proud to have been able to contribute to the global and national learning throughout participating in a range of clinical research trials.

Our clinical trials include:

- **SaNOtize Nasal Spray Trial –** ASPH were the first and only UK site to test out this new nasal spray device for the treatment of COVID. The nasal spray dispenses nitric oxide to kill COVID in the nasal passage preventing it from entering the lungs. This study has gained plenty of publicity with it being reported in the Sunday Times and ITV news. We have successfully recruited 80 participants and the results look very promising - we are hoping to have these published in a journal soon

- **The RECOVERY Study** – This was an urgent Public Health England (PHE) study at the beginning of the pandemic to determine the best course of action to treat hospitalised COVID patients. Our amazing researchers worked tirelessly throughout the pandemic recruiting 250 patients. The study has constantly evolved over the last year as new treatments have been introduced. As a direct result of this research, dexamethasone and tocilizumab have been proven to be effective and are now used as standard of care

Andy Field, Chairman, donating convalescent plasma as part of NHS Blood and Transplant's programme

- **The SIREN Study** – We have managed to recruit over 400 staff members across the trust making us the largest recruiting site in the UK! Participants in this study have swabs and bloods done regularly to test for potential COVID infections as well as measuring their COVID antibodies from infection and vaccine. As this study is ran by PHE, the blood samples they receive help them make important decisions regarding the vaccine rollout across the country

- **DEFEAT Study** – We were the first site in the UK to test the effects of leflunomide – a rheumatoid arthritis drug shown to have anti-inflammatory and antiviral properties. We recruited over 60 participants during the second wave earlier this year. This study now has multiple centres with sites opening up in India as well

- **ANCON Study** – A breath test study which uses Nanotechnology Biomarker Tagging (NBT) to analyse exhaled breath for coronavirus. We recruited 331 participants whose breath helped create a profile for accurate COVID detection within 10-15 minutes

- **REMAP-CAP** – This was an ITU study looking into effective COVID treatment for individuals that were severely infected. Our research team worked through both waves to recruit 30 patients. Similar to the RECOVERY study, the various treatment arms have been modified throughout the pandemic with tocilizumab shown to have a significant effect at treating severe disease

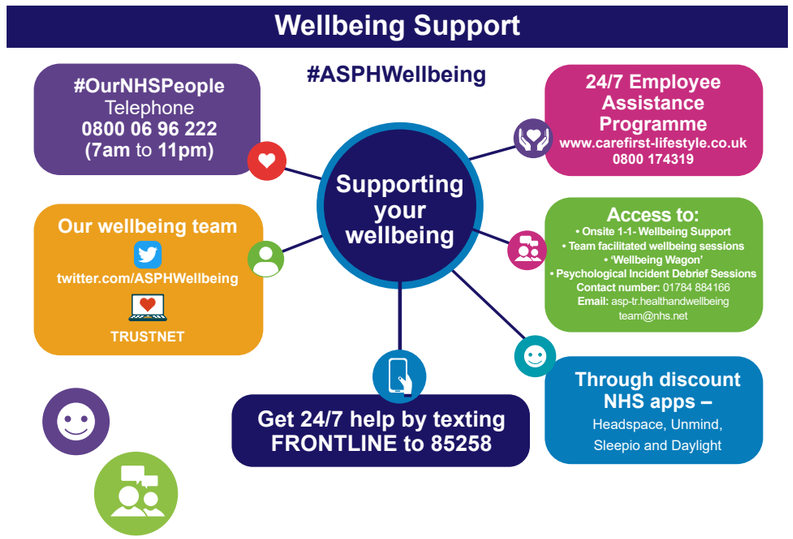
We would like to thank all individuals who participated in these crucial studies which have undoubtedly had a huge impact on treatment and our long term understanding of COVID-19.

Strategic objective 2: People

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

Our key achievements over the last year are:

The Health and Wellbeing of Team ASPH, patients and community



Pictured L-R: Laurence Gamlen, Staff Wellbeing and Pastoral Care Lead, joined by Suzanne Rankin, Chief Executive, visiting teams across the Trust with the Wellbeing Wagon.

Looking after the health and wellbeing of Team ASPH is always important, but has been absolutely imperative during the past year. During this challenging time we increased our range of wellbeing support significantly and continuously strived to find new and creative ways for colleagues to access support for their emotional wellbeing and health.

One initiative is the 'Wellbeing Wagon' run by our Staff Wellbeing and Pastoral Care Lead, Laurence Gamlen Laurence visits teams across the Trust several times a week, delivering treats and health and beauty products which have been kindly donated by local fundraising groups and organisations. The couple of moments that staff get to spend with Laurence may only be brief but they make a real difference and we have received really positive feedback from teams who really appreciate the gesture.

The Project Wingman Team in the Education Centre at St. Peter's Hospital

Project Wingman is a group of current and former airline staff who visit NHS Trusts and healthcare services to provide space for staff to relax before, during and after their shifts and to support with their wellbeing. The group landed at ASPH towards the end of January, and has been providing a first class lounge service for colleagues to take time out of their day to relax, enjoy a cup of tea and a chat with airline staff.

Send a message of love and support

We also sought inventive new ways to help keep inpatients connected with their loved ones during these difficult times where visiting has been restricted. We launched a range of initiatives including face and phone time with loved ones, virtual consultations and free newspapers and snacks. We have also worked closely with our healthcare partners to share critically important public health information to our community. Recently, a new Health and Wellbeing Officer has been appointed to continue to shape and grow the work put in place over the past year.

COVID recruitment hub

Like many, we have transformed the way we work as individuals and teams across ASPH throughout the pandemic in line with national guidance. Some of this transformation includes colleagues working remotely where possible, some members of Team ASPH being redeployed across the Trust to provide additional support to ensure that we delivered care for those who needed it the most, as well welcoming new and former NHS colleagues to aid service provision. To accommodate these new workforce requirements we launched an innovative COVID recruitment hub.

Engaging with members of our local community was an important aim of the hub and we wanted to offer a mechanism for people to get involved. During the last year, it has been remarkable to see how many people wished to support their local healthcare provider. We were aware that a lot of people were either furloughed or had lost their jobs and were looking for work or even a change of career. The hub gave a focal point to engage with the communities around ASPH and recruited more than 500 people from our local community over the last year.

A drawing commissioned by Well North, which tells the story of a staff member's experience being redeployed to ICU during the COVID pandemic.

ASPH Vaccination Hub

An amazing example of this in action was the ASPH COVID vaccination hub. Since launching on 21st January, the team have given over 25,500 COVID vaccinations to Team ASPH, healthcare colleagues and members of our local community – a phenomenal achievement supporting the delivery of this life-saving vaccine.

Organising a service like this from scratch is an enormous task and it doesn't happen without a huge amount of hard work, and a great deal of team work, welcoming members of the community from airline/hospitality industries to work alongside trust colleagues, and was a real joint effort. The work of our vaccination hub has been recognised locally and nationally – with a special mention from Health Secretary of State, Matt Hancock. This was a real turning point in our journey through the pandemic and helped give us all a sense of much needed hope earlier this year and the professionalism and dedication shown has been just incredible.

Top: The team who worked in the COVID vaccination hub
Below: An image of the COVID vaccination hub illuminated in yellow for the National Day of Reflection on 23rd March 2021

Award-winning Employees

This year has been like no other, and to mark this, the Queen recognised key workers and members of the community for their extraordinary response throughout the pandemic in her Birthday and New Year's Honours Lists. Here at ASPH we were delighted and extremely proud that Maciel Vinagre, Assistant Manager Hotel Services, was named in the Queen's Birthday Honours List 2020, and both Sara Robertson, Matron – Neonatal Intensive Care Unit, and Louise Maltby, Matron – Intensive Care Unit, were named in the New Year's Honours List 2021. These members of staff were all recipients of British Empire Medals (BEM) – a fantastic achievement and well deserved recognition.

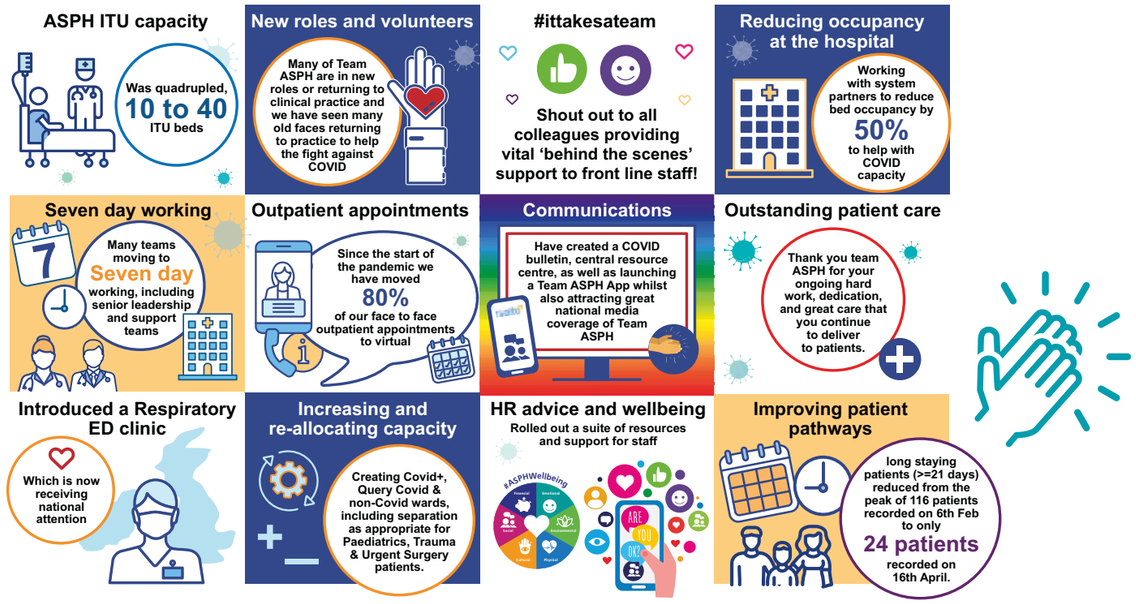
Louise Maltby, Matron - Intensive Care Unit

Echoing this, we held our first-ever ASPH New Year's Honours awards ceremony to mark the extraordinary achievements of individuals and teams at the Trust to recognise their hard work and effort over the past year. Awards were handed out in categories such as 'Passion for Excellence', 'Unsung Hero' and 'Inspiring Leader', all of which were nominated by colleagues.

ASPH New Year's Honours Awards Ceremony 2021

Suzanne Rankin, Chief Executive, said:

"It has been wonderful to be able to hold the first-ever ASPH New Year's Honours List award ceremony. Team ASPH has been through an extraordinary experience over the last year but what has been clear throughout is just how remarkable all members of the team have been showing, their compassion, professionalism and resilience. A number of colleagues have surpassed all expectations and have truly gone above and beyond in their selfless support for patients and colleagues and it's with great humility and pride that I have been able to celebrate their achievements with them (albeit social distanced) at the ceremony. Huge congratulations to all the winners and runners-up!"



Keeping Team ASPH, patients and partners up-to-date

Clear and concise communication and engagement has never been more important than over the past year. We adapted at pace to respond to the needs of our colleagues, patients and partners, co-ordinating with local, regional and national partner organisations to roll out a new strategy.

As demonstrated throughout this report, providing timely essential information as well as enabling opportunity for open discussions, in new and creative ways through design, digital and virtual channels, was essential. Feedback has been very positive of the approach which has helped colleagues, patients and partners feel informed and connected to the hospital, during such a challenging time.

Strategic objective 3: Modern Healthcare

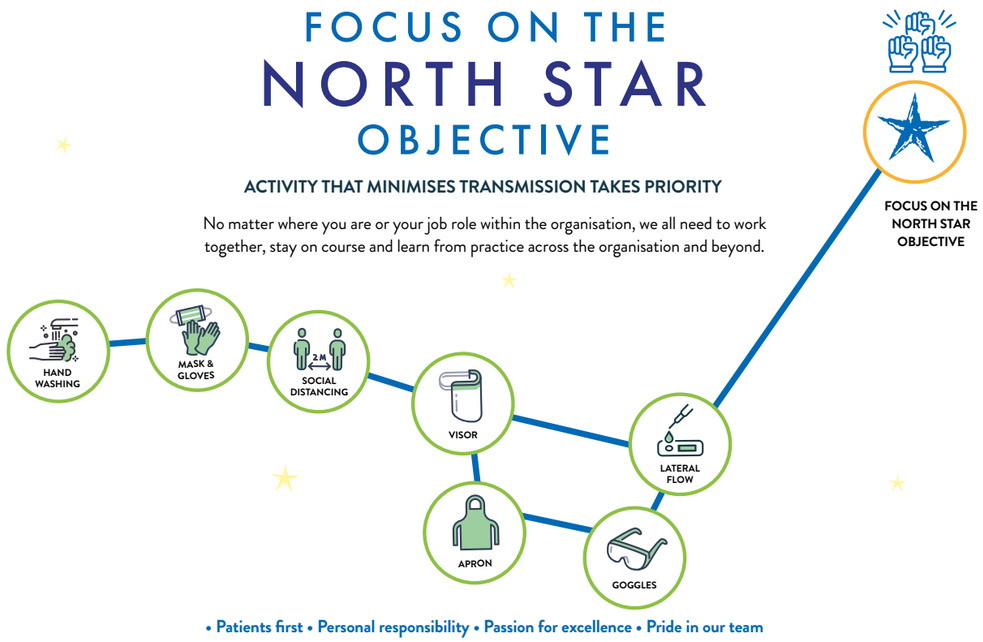
Delivering the most effective and efficient treatment and care through standardisation in the delivery and outcome of clinical services

Our key achievements over the last year are:

Keeping our community and Team ASPH safe during the pandemic

Keeping ourselves, loved ones and our community safe has been the main priority for the Trust during the pandemic.

As part of this work we have taken the opportunity to build on the huge amount of transformation we have achieved throughout. We have set a new 'North Star' objective within the 'Together we Care' strategy and for the Trust that seeks to: "End health and care acquired infections for the team, patients and the community we serve." To achieve this we have created and implemented a new, fit-for-purpose, modern operating model, strengthened by our innovative and robust Infection Prevention and Control strategy launched in March 2020. So far, this has been hugely successful with the Trust recording some of the lowest cases of hospital acquired COVID across Surrey.



"End health and care acquired infections for the team, patients and the community we serve."

Virtual and digital clinics at ASPH

In October 2019, the MSK therapies team at ASPH began trialling video consultations, as part of the NHS England and NHS Improvement national video consultation pilot. Due to the COVID pandemic, the pilot was rapidly rolled out Trust wide in early 2020, which meant that hundreds of appointments were taking place by video consultation each week.

Feedback from patients has been positive around the implementation of video consultations at ASPH. Around 90% of patients that were surveyed following their video consultation, felt that their needs were met during their appointment and gave a star rating of 4.5/5 stars for the platform being 'easy to use'. Patients also reported benefits like saving time from travelling to and from appointments, saving money on travel, car parking and childcare arrangements and a reduction in time taken off work for attending appointments.

Due to the successful shift to both video and telephone consultations, ASPH is now looking to maintain 50% of outpatients to take place virtually, which aligns with The NHS Long Team Plan to committing to reducing travel mileage, improving patient care and experience, and improving efficiency and capacity of outpatient services across the NHS in a sustainable way.

Feedback received from patients who have used Attend Anywhere for video appointments

"One of the biggest changes we made during the COVID situation was switching to virtual patient appointments."

Digital checkpoints at the main entrance of St. Peter's Hospital

Digital checkpoints

The installation of innovative digital checkpoints at the main entrances across the Trust, which staff and patients must pass through each time they enter one of our hospitals has been a great success. This helps to ensure everyone is following national guidelines as well as having their temperature checked via one of our thermal cameras.

We have also undertaken a huge programme of Workplace Risk Assessments across the organisation. To assist colleagues, a digital Workplace Safety Tooklit been produced full of helpful resources to keep everyone safe when at work.

Architect's drawing of the new modular unit set to open in summer 2021

Large scale site transformation

The completion of land sales at both sites in 2018/19 was a milestone in the history of the Trust. Despite the pandemic we have made good progress with a number of large healthcare estate improvements, which will help to transform services and enhance facilities for Team ASPH and our community, including:

Improving emergency care provisions at St. Peter's Hospital

Following the Trust being awarded £15m for improvements to emergency care provisions, work is progressing at pace to construct a new two floor unit which is being built in the old Emergency Department car park at St. Peter's Hospital. This new unit is an exciting development which will have 62 trolley or bed spaces across the two floors, with treatment and clinical support rooms, offices, staff rooms, and changing facilities on both floors. A key part of this space will be a new Priority Assessment Unit to enable patients to be safely discharged home within 24 hours, diverting patients from our busy Emergency Department. Co-designed by clinical teams, patients and partners to provide an enhanced, fit for purpose department for adults, children and young persons that supports Trust objectives and ensures patients are treated in the right place, at the right time.

Ashford outpatient, diagnostic and elective hub

It is a really exciting time for Ashford as we are now at a stage where nearly two years of planning is coming to fruition and the Ashford site is becoming the hub for outpatient, diagnostic and elective services. A brand new theatre has been built in the main theatre complex, and two further modular theatres, as well as two theatres extensively refurbished. We have opened a brand new dedicated elective inpatient surgical ward and later this year, a four bedded Enhanced Care Unit (ECU) will be added.

During the last year, around 60% of all outpatient appointments were at Ashford, compared to 40% the year before. This is set to continue in the coming months as we carry on with the restoration and recovery of all services following the last COVID wave. Similarly in relation to diagnostics, the proportion of CT, DEXA, and ultrasound scans undertaken at Ashford have also significantly increased over the last year as we have focused their delivery at Ashford, which has been aided by a new additional CT scanner, installed last August.

This move will bring a number of key benefits to patients and Team ASPH. Having a dedicated elective site aligns with the NHS Long Term Plan (2019) which will help to ensure that inpatient beds can be dedicated to either emergency patients arriving via A&E or for patients arriving for planned surgery.

Theatre at Ashford

Parking at St. Peter's

At the beginning of January 2021 we were delighted to open the new multi-deck car park at St. Peter's Hospital to improve parking for patients and colleagues. It provides additional parking spaces and direct access to the main reception of the hospital with level access from all floors by using the lifts. There is dedicated Blue Badge parking on level 2, adjacent to the front of the hospital and main reception.

All St. Peters patient car parks are now ANPR (Automatic Number Plate Recognition) equipped so there is no need for a ticket to enter or exit and includes 8 electric charging points.

New multi-storey car park at St. Peter's Hospital

New catering facilities

We have officially unveiled new staff and visitor catering services, as part of a move to offer a long-term food solution across our sites. The services, which include a staff restaurant and three cafes, have been launched across the Trust, giving staff and visitor's access to safe, modern and commercially viable areas to reset and refuel across the Trust's two hospitals.

The menu has also been updated and offers a more diverse food offering, which has been received really positively by the team. We have also launched an app which enables members of the team to pre-order their food and drinks and collect at a convenient time for them, making the ordering process more efficient and reducing queuing times. With more than 90 per cent of the food being freshly produced onsite, the Trust is in line to quickly meet requirements set out in the Hospital Food Review – a recent programme launched by celebrity chef, Prue Leith and Phillip Shelley, chair of the Review and a Former Chair of the Hospital Caterers Association.

Edu Kitchen at St. Peter's Hospital

Strategic objective 4: Digital

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

Our key achievements over the past year are:

Surrey Safe Care

Surrey Safe Care is the collaborative organisational, transformation programme which will introduce our new Electronic Patient Record across ASPH and Royal Surrey Foundation Trust.

Surrey Safe Care is designed to transform the way in which we deliver care, enabling an exceptional healthcare experience for patients and teams that is regionally integrated and personally delivered.

The deployment of the fully-integrated system involves a major digitally-enabled transformational change programme that will engage and touch every part of both Trusts, impacting and engaging with colleagues at all levels.

- Deliver a better experience of care for our patients
- Supporting our teams to deliver the best care possible
- Reduce treatment delays
- Reduce medication errors
- Reducing healthcare acquired infections

The latest event in the programme was a week-long Workflow Safety Check and Showcase (Future State Validation). The Showcase was an exciting series of over 80 interactive virtual sessions designed to demonstrate and 'safety check' the new workflows within Surrey Safe Care. Each session was targeted to specific services and allowed staff members to review and highlight any safety concerns or critical issues before signing off Surrey Safe Care system ready for testing and training.

The event was a fantastic engagement opportunity for colleagues to see their new way of working, which was reflected in the phenomenal number of bookings easily surpassing 4,000 across the week. The showcase was a great success and acts as a crucial part of the assurance process so we can be confident in knowing that Surrey Safe Care will be safe, secure and fit-for-purpose.

Enabling Remote Working

Due to the pandemic and the government restrictions that were put in place, the Trust had to quickly enable nearly 1000 additional staff to work from home within a short timeframe. Because of manufacturing in the Far East slowing down and increased demand from organisations, the waiting time for laptops were 12-18 weeks, with some suppliers having no stock at all.

The Trust had to find a creative solution that could be implement relatively quickly, secure by design and cost effective compared to laptops. We learned about a new technology called Windows Virtual Desktop (WVD) from Microsoft which we were able roll out within weeks and meet all requirements.

The solution allows staff to use their own devices at home to easily access a familiar Trust 'desktop', complete with required applications and the ability to use smartcards and dictaphones. We are continuing to provide this solution and hope to adopt it as a permanent part of our remote working infrastructure.

Cyber Security and Data Security

Our Trust relies on data systems which are fundamental to patient care so it is really important that we do everything possible to mitigate the risk of cyber attacks. With digital platforms for the delivery of patient care accelerating due to the pandemic, we launched an extensive cyber security and data campaign to remind colleagues of their responsibilities when handling, storing and transferring information safely, securely and in an appropriate way.

Unlocked Screen?
Fishy email?
Swiping people in?
Weak passwords?

...Keep I.T. confidential

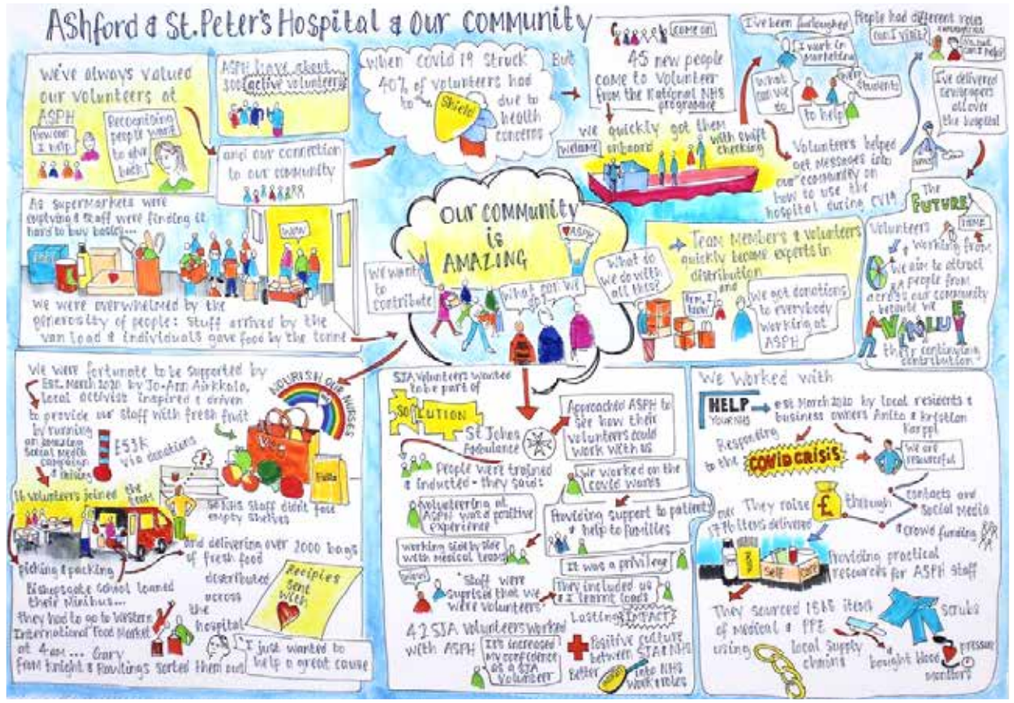
Strategic objective 5: Collaborate – Sustain and Thrive

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

Our key achievements over the last year are:

ASPH as an anchor institution

Support from the local community over the past year has been both humbling and overwhelming. Financial donations from NHS Charities Together (with donations from Captain Sir Thomas Moore) and the community provided nursing staff with a nutritious hot meal made from fresh ingredients, iPads for patient communication with loved ones, PPE supplies and an outdoor wellness area for colleagues to eat, relax and socialise. As well as the community taking such great care of us, we wanted to give back too and some of the ways we have done this include supporting healthcare partners across the county with supplies, providing employment for those who had been furloughed or lost their jobs due to the pandemic, as well as continuing to support our local foodbanks This last year has enabled us to strengthen our relationships and further embed our position as an anchor institution within the community we serve.



A drawing by Well North which tells the story of how the community responded and supported the Trust during the first wave of the COVID pandemic.

Support from the local community

Collaborating in new ways with new partners

For the first time in history ASPH partnered with local independent hospitals, BMI Runnymede and Nuffield Health Woking, who handed over wards and theatres to ASPH patients which provided space to care for COVID patients. These new collaborations have harnessed sustainable ventures to continue to provide the best care and facilities possible for Team ASPH and patients.

A recent example of this is **Lighthouse laboratory project**, where we have worked imaginatively with our partners at pace to meet the needs of the national effort, creating a state of the art lab that will process an incredible 30-40,000 PCR tests a day across Berkshire and Surrey.

The Bracknell Lighthouse Laboratory is run by Berkshire and Surrey Pathology Services, on behalf of NHS Test and Trace.

Berkshire & Surrey Pathology Services NHS

NHS Test and Trace

We are grateful to our partners:

NHS Ashford and St. Peter's Hospitals NHS Foundation Trust
NHS Frimley Health NHS Foundation Trust
NHS Royal Berkshire NHS Foundation Trust
NHS Royal Surrey NHS Foundation Trust
Pirbright Institute

Progression with the North West Surrey Health and Care Alliance

Along with partners across North West Surrey, the Trust has now signed the NWS Alliance Agreement and a Board has been constituted. By bringing together local health and care organisations, the Alliance is using all its experience and know-how to improve the way public money is spent and making sure big decisions are taken together for the benefit of local people.

This is one of the largest public sector Alliances in the UK and is taking a different approach to improving the health and wellbeing of the 370,000 people living across Elmbridge, Runnymede, Spelthorne and Woking.

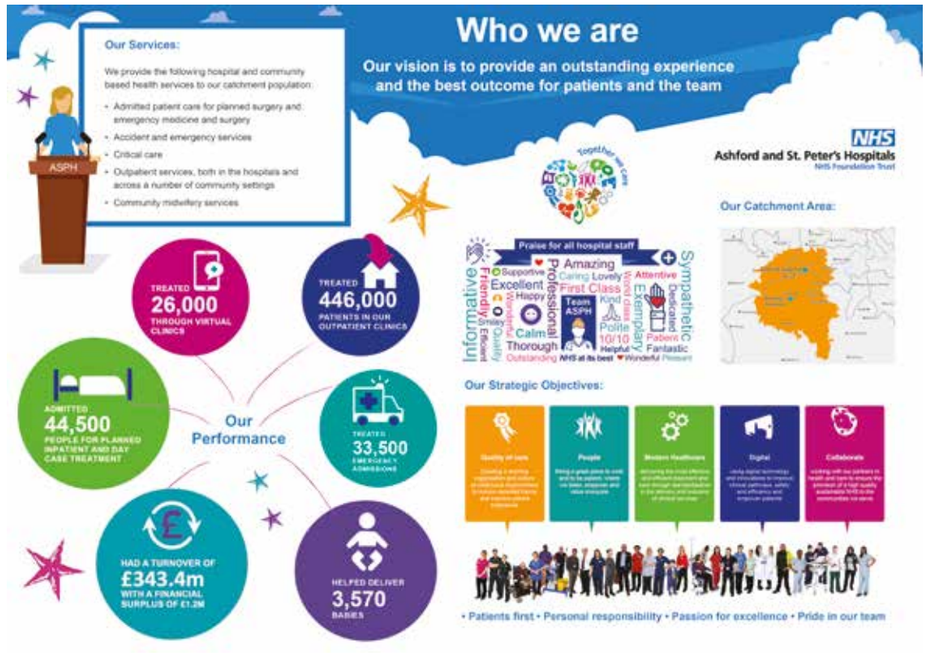
Our local GP Federation, to run our Urgent Treatment Centre (UTC)

An example of NWS Alliance partner working is ASPH joining forces with NICS, our local GP Federation, to run our Urgent Treatment Centre (UTC) in April 2020. This collaboration is the first partnership between ASPH and NICS and has provided an opportunity for the flexible provision of emergency services for our local population. The UTC provides a service staffed by local GPs and Nurse/Paramedic practitioners to deliver services for patients of all ages with minor injuries and minor illnesses. Delivery through our local GP Federation provides a link between Primary and Secondary care as the staff know the local area and services that are available. Patient attendances have returned too, and are exceeding, pre-pandemic levels and the UTC is developing and providing innovative care to support the increased demand.

NICS as an organisation has further supported the Trust through the delivery of Respiratory ED Clinics (REED) that have helped patients who have had COVID to be allowed home earlier or directly from the emergency department and followed up through dedicated virtual clinics. This has enabled us to maximise capacity within the Trust and ensured that patients are monitored and have access to early escalation back to the Trust if and when needed. This partnership with NICS has provided huge benefits and we will be looking at ways to develop this collaborative approach in the future.

ASPH Strategy Re-fresh

The pandemic has brought a different focus to the next two-five years for ASPH. We have embarked on a mid-term Strategy Re-fresh to reflect this. The engagement process - insight from Team ASPH, partners, patients and our community - will be a key springboard to setting the future direction of the Trust.



3. ACCOUNTABILITY REPORT

Directors' Report

The Directors present their report for the financial year 1 April 2020 to 31 March 2021, which incorporates a summary of our overall performance against our corporate objectives.

Our Executive Team

Our Executive Team over the last year has comprised:

- **Suzanne Rankin,** Chief Executive (on secondment to NHS Test and Trace as National Director for Containment 1 June – 30 September 2020)
- **David Fluck,** Medical Director (Acting Chief Executive from June – 30 September 2020)
- **Andrea Lewis,** Chief Nurse (from October 2020 – previously Interim Chief Nurse)
- **Simon Marshall,** Director of Finance and Information
- **Louise McKenzie,** Director of Workforce Transformation
- **Tom Smerdon,** Director of Strategy and Sustainability
- **James Thomas,** Chief Operating Officer

Non-Executive Directors

During the year our Non-Executive Directors have been:

- **Andy Field,** Chairman
- **Dami Adedayo** (joined November 2020)
- **Mike Baxter** (left end October 2020)
- **Jane Dale**
- **Chris Ketley**
- **Neil Hayward**
- **Keith Malcouronne**
- **Yvonne Obuaya,** Associate Non-Executive Director (left end of August 2020)
- **Arun Thiyagarajan,** Associate Non-Executive Director (joined November 2020)
- **Meyrick Vevers**
- **Marcine Waterman,** Deputy Chairman

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

Director disclosures

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

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

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

Remuneration Report

Remuneration and Appraisals Committee and Policy on Remuneration of Senior Managers

The Remuneration Committee consists of four Non-Executive Directors chaired by the Senior Independent Director. The Committee met three times in 2020/21 and attendance is set out on p90.

The Committee sets the policy, and the level of remuneration and terms and conditions of the Executive Directors of the Trust. The Committee receives an annual report on the performance of Executive Directors in the context of strategic objectives which feeds into decisions about remuneration levels. Mindful of its duties in managing public funds, in particular as one or more senior managers are paid in excess of £150,000 (the amount set out in guidance issued by the Cabinet Office), its policy is set to balance the need to appoint and retain Executive Directors within the Trust, whilst reflecting a pay range that acknowledges that the organisation is performing well financially. This year the Committee confirmed the remuneration for the substantive Chief Nurse, and for the period of the Chief Executive's secondment to NHS Test and Trace; the Acting Chief Executive and Acting Medical Director. The Committee reviewed the remuneration of the Medical Director this year and confirmed a move to Very Senior Manager (VSM) pay arrangements to reflect the role. The pay award for Executive Directors for 2020/21 was made in accordance with guidance from NHS England and NHS Improvement recommending an annual pay increase for VSMs of a consolidated increase of 1.03 %.

All Executive Directors contracts were open-ended with notice periods for six months. There were no contracts containing a provision for compensation over and above legal entitlement for early termination. In 2020/21 all Executive Directors were paid through the Trust's payroll.

The Nominations and Executive Appointments Committee consists of four Non-Executive Directors (and the Chief Executive when matters pertain to Executive Directors), and is chaired by the Trust Chairman.

Remuneration of Chairman and Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is agreed by the Council of Governors following review by its Remuneration and Appraisal Committee. The Committee decided to implement the local discretion as set out in NHS England/Improvement guidance to award the supplementary payments in recognition of extra responsibilities and to distribute this across all Non-Executive Directors, remaining within the maximum financial value recommended for the Trust. This was in recognition that all Non-Executive Directors chair a sub-committee of the Board. Details of this Committee are set out on p94.

Expenses

In 2020/21 the Trust paid out a total of £470 (2019/20- £6,694) in expense payments to 1 (2019/20 – 7) Trust Board members and Senior Managers with significant financial responsibility. Further analysis of these expenses by Trust Board member is available on the Trust website at **www.ashfordstpeters.nhs.uk/board-member-expenses**

The role of Governor of a Foundation Trust is voluntary but the NHS Act and the Constitution states that the Trust 'may pay travelling and other expenses to members of the Council of Governors at rates decided by the Trust'. The Trust has a policy on such reimbursement and this was last approved in November 2019. In 2020/21 a total of £58 (2019/20- £1,794) was paid out in such expenses to 1 (2019/20 – 11) Governors.

Fair Pay Multiple

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

The banded remuneration of the highest paid Director in the Trust in the financial year 2020/21 was £232,500 (2019/20- £247,500). This was 7.4 times (2019/20 – 8.1) the median remuneration of the workforce, which was £31,365 (2019/20- £30,401). Total remuneration of the highest paid Director includes salary and benefits-in-kind; it does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The highest paid Director in both years was the Trust's Medical Director.

Salary and pension entitlements of senior managers for the year to 31 March 2021

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

A) Remuneration

Name and Title	2020-21 Salary (bands of £5,000)	2020-21 Benefits in Kind (Rounded to the nearest £100)	2020-21 All pension-related benefits (bands of £2,500)	2020-21 Total (bands of £5,000)	2019-20 Salary (bands of £5,000)	2019-20 Benefits in Kind (Rounded to the nearest £100)	2019-20 All pension-related benefits (bands of £2,500)	2019-20 Total (bands of £5,000)
Executive Team	£000	£00	£000	£000	£000	£00	£000	£000
Suzanne Rankin, Chief Executive (Seconded to NHS Test and Trace from 1 June 2020 to 30 September 2020)	140-145	36	-	145-150	180-185	77	-	190-195
Simon Marshall, Director of Finance and Information	140-145	55	32.5-35.0	180-185	140-145	63	27.5-30.0	175-180
Dr David Fluck, Medical Director (Acting Chief Executive from 1 June 2020 to 30 September 2020)	225-230	57	-	230-235	235-240	66	-	245-250
Faris Zakaria, Acting Medical Director (from 1 June 2020 to 30 September 2020)	45-50	-	10.0-12.5	55-60	-	-	-	-
Louise McKenzie, Director of Workforce Transformation	130-135	85	35.0-37.5	175-180	125-130	82	22.5-25.0	160-165
Sue Tranka, Chief Nurse (to 31 December 2019)	-	-	-	-	95-100	-	22.5-25.0	120-125
Tom Smerdon, Director of Strategy and Sustainability	115-120	80	25.0-27.5	150-155	115-120	77	107.5-110.0	230-235
James Thomas, Chief Operating Officer	125-130	56	-	130-135	135-140	61	30.0-32.5	170-175
Andrea Lewis, Chief Nurse (Interim from 13 December 2019 to 30 September 2020)	120-125	-	-	120-125	35-40	-	-	35-40
Chairman and Non-Executives								
Andy Field, Chairman	45-50	-	-	45-50	45-50	-	-	45-50
Meyrick Vevers, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Prof. Hilary McCallion, Non-Executive Director (to 31 August 2019)	-	-	-	-	5-10	-	-	5-10
Neil Hayward, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Prof. Mike Baxter, Non-Executive Director (to 31 October 2020)	5-10	-	-	5-10	10-15	-	-	10-15
Keith Malcouronne, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Chris Ketley, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Marcine Waterman, Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Jane Dale, Non-Executive Director (from 1 January 2020)	10-15	-	-	10-15	0-5	-	-	0-5
Dami Adedayo, Non-Executive Director (from 1 November 2020)	5-10	-	-	5-10	-	-	-	-

a) Included within the of salary for Dr David Fluck is salary relating to his medical work as a Consultant at the Trust and additional pay in respect of a period as Acting Chief Executive during 2020/21.

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

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

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

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

f) The allowance for chairing a sub- Committee of the Trust Board has been distributed across all Non-Executive Directors in 2020/21 (2019/20-£nil). No remuneration was waived by Directors, no allowances were paid in lieu and there were no payments in respect of golden hello's.

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

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

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

B) Pension Benefits

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real Increase/ (Decrease in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's Contribution to Stakeholder Pension (to nearest £100)
Executive Team	**£000**	**£00**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Suzanne Rankin, Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
Simon Marshall, Director of Finance and Information	2.5-5.0	(2.5)-0	35-40	65-70	607	26	664	-
Dr David Fluck, Medical Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
Faris Zakaria, Acting Medical Director (from 1 June 2020 to 30 September 2020)	0-2.5	0-2.5	40-45	95-100	797	11	863	-
Louise McKenzie, Director of Workforce Transformation	2.5-5.0	0-2.5	40-45	85-90	692	31	754	-
Tom Smerdon, Director of Strategy and Sustainability	0-2.5	(2.5)-0	25-30	45-50	416	20	459	-
James Thomas, Chief Operating Officer	(7.5)-(5.0)	(22.5)-(20.0)	20-25	40-45	438	0	353	-
Andrea Lewis, Chief Nurse (Interim Chief Nurse from 13 December 2019 to 30 September 2020)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-

Notes:

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

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

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

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

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

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual concerned was entitled to a GMP, this would have affected the calculation of the real increase in CETV in 2019/20.

Suzanne Rankin
Accounting Officer

10 June 2021

Staff Report

Analysis of staff costs

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

	2020/21			2019/20		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	188,112	166,440	21,672	163,080	144,256	18,824
Social security costs	18,511	16,413	2,098	16,346	14,562	1,784
Apprenticeship levy	891	790	101	798	711	87
Employer contributions to NHS Pension scheme	29,281	25,962	3,319	26,329	23,455	2,874
Employer contributions to National Employment Savings Scheme (NEST)	32	28	4	26	23	3
Termination benefits	-	-	-	-	-	-
Agency/contract staff	13,266	-	13,266	16,263	-	16,263
Total gross staff costs	**250,093**	**209,633**	**40,460**	**222,842**	**183,007**	**39,835**
Recoveries from other organisations	(8,655)	(8,153)	(502)	(6,997)	(6,657)	(340)
Staff costs capitalised	(697)	(697)	-	(913)	(913)	-
Total staff costs	**240,741**	**200,783**	**39,958**	**214,932**	**175,437**	**39,495**

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

Employer contributions to the NHS Pension scheme in 2020/21 include £8,870,000 (2019/20 £7,979,000) paid directly by NHS England on the Trust's behalf. This follows an increase in the contribution rate for employers of 6.3%.

Average staff numbers

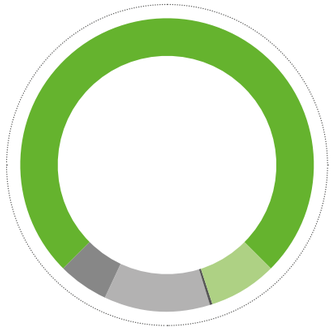
The Trust's average staff numbers in whole time equivalents (WTEs) during the year is shown below:

	2020/21			2019/20		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	No.	No.	No.	No.	No.	No.
Medical and dental	608	608	-	565	565	-
Administration and estates	847	847	-	772	772	-
Healthcare assistants and other support staff	920	920	-	850	850	-
Nursing, midwifery and health visiting staff	1,007	1,007	-	919	919	-
Scientific, therapeutic and technical staff	310	310	-	286	286	-
Healthcare science staff	99	99	-	97	97	-
Bank and agency staff	731	-	731	704	-	704
	4.522	**3,791**	**731**	**4,193**	**3,489**	**704**

The total of 4,522 WTE compares to 4,193 WTE for 2019/20. The largest part of our workforce is nursing and midwifery, and medical and dental staff who account for 43% of our permanent employees.

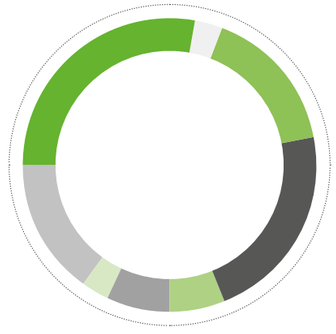
Staff costs 2020/21

Salaries and wages	75.2%
Social security costs	7.4%
Apprenticeship levy	0.35%
Employer contributions to NHS Pension scheme	11.7%
Employer contributions to National Employment Savings Scheme (NEST)	0.01%
Agency/contract staff	5.3%



Staff in Post as at 31 March 2021

Nursing and Midwifery Registered	28%
Add Prof Scientific and Technic	3%
Additional Clinical Services	16%
Administrative and Clerical	22%
Allied Health Professionals	6%
Estates and Ancillary	7%
Healthcare Scientists	3%
Medical and Dental	15%

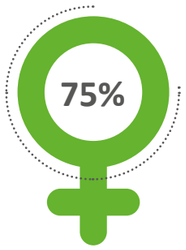


Gender Split

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

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

Gender as % of Total Workforce



Directors

Headcount Numbers			
Gender	Exec	Non Exec	Total
Female	3	3	**6**
Male	4	7	**11**
Total	**7**	**10**	**17**

♀ 36% ♂ 64%

Senior managers

Headcount Numbers			
Gender	Full Time	Part Time	Total
Female	139	71	**210**
Male	69	9	**78**
Total	**208**	**80**	**288**

♀ 27% ♂ 73%

All Perm/FTC staff

Headcount Numbers			
Gender	Full Time	Part Time	Total
Female	2164	1157	**3321**
Male	959	132	**1091**
Total	**3123**	**1289**	**4412**

By pay band

Pay Band	♀	♂
1	11.5%	4.9%
2	9.2%	2.6%
3	7.9%	1.6%
4	14.1%	2.6%
5	12.2%	2.1%
6	7.5%	1.5%
7	3.2%	1.0%
9	0.8%	0.3%
8A	0.4%	0.1%
8B	0.2%	0.2%
8C	7.7%	7.1%
8D	0.1%	0.1%
Med and Dental	0.1%	0.1%
Exec	0.1%	0.2%
Non Exec	0.4%	0.3%
Local	11.5%	4.9%
Grand Total	**75.3%**	**24.7%**

Sickness absence data

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

Staff Turnover data

NHS turnover data is published by NHS Digital at the following link:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Policies and Actions Applied During the Financial Year

We have a full range of Workforce policies held on our internal Trustnet site. Our Workforce Teams provide guidance and support on these policies to both managers and staff. These policies include Recruitment and Selection policy which sets the process for ensuring fair employment, training and career development opportunities.

Our response to the pandemic meant that we needed to rapidly redesign our operational policies and processes to support staff and ensure that their working environment and practices were as safe as possible. This included real-time daily sickness and absence reporting, clear processes for self-isolating, testing, being trained on appropriate PPE, adjusting working environments, redeploying staff, ensuring that every individual staff member had completed a risk assessment and put in place actions to mitigate their risks.

We have also maintained our approach of regular review and update of a number of policies which included Medical Appraisal Policy; Shared Parental Leave Policy; Appeal Policy; Partnership and Recognition Agreement Policy and Annual Leave Policy.

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

We have also introduced a new Acting Up and Secondment Policy in order to ensure that we have a consistent and equitable process in place for all staff. We hope that this results in a more diverse range of colleagues applying for secondments and the like and in turn results in more diversity in promotions and within our more senior cadre.

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

Raising concerns

The Trust is committed to creating a culture where everyone feels able and confident to speak up. This was at the heart of the #RightCulture programme launched in 2014. In addition to accessing advice and support from HR and line management colleagues, the Trust has an active Freedom to Speak Up Guardian (FTSUG). There are ten appointed FTSU Ambassadors, spread across a number of disciplines and levels in the Trust including, Nursing, Maternity Admin, Midwifery, Nurse Educators, Pharmacist, Pain team, Occupational Health, IT and Training.

OH performance and Flu campaign

The Trust runs an annual flu vaccination programme for staff with a dual purpose of protecting our healthcare workers as well as protecting our patients and members of the public. In 2020/21 83% of frontline staff received the flu vaccine, and although the target for this year was 100%, this was an excellent response from frontline staff and we far exceeded our performance from previous years. The campaign was led by our Director of Workforce Transformation, and championed by all of our peer vaccinators including our Chief Executive.

Countering Fraud and Corruption

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

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

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

Expenditure on consultancy

During 2020/21 the Trust spent £1,402,000 on consultancy compared to £1,139,000 in 2019/20. The expenditure was across a number of different areas and projects with the largest spend relating to the Surrey Safe Care transformation programme.

Off-payroll engagements

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

In order to comply with the amended IR35 intermediaries' legislation, and the guidance from NHS Improvement, the Trust notified all contractors that payments for engagements captured by IR35 would no longer be made gross after 31 March 2017 and would be subject to deduction of tax and PAYE at source. As such there were no reportable off-payroll engagements in existence during 2020/21 or as at 31 March 2021, as all payments are made net of tax and NI contributions, either through the Trust payroll or through the Trust's arrangement with Plus Us and supporting employment agencies.

Disclosures are set out in the tables below.

For all off-payroll engagements as of 31 March 2021, for more than £245 per day:

	No
Number of existing engagements as of 31 March 2021	-

For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day:

	No
Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	-
Of which:	
Number not subject to off-payroll legislation	-
Number subject to off-payroll legislation and determined as in-scope of IR35	-
Number subject to off-payroll legislation and determined as out of scope of IR35	-
Number of engagements reassessed for compliance or assurance purposes during the year	-

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

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

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

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

Exit packages

Details of exit packages agreed during the year to 31 March 2021 are set out in the following table:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	5	5
£10,001 – £25,000	-	2	2
Total number of exit packages by type	-	7	7
Total resource cost (£'000)	**-**	**55**	**55**

In 2019/20 there were forty seven exit packages at a cost of £1,864,000 of which £1,830,000 was for compulsory redundancies.

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

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

Staff Survey

The National Staff Survey provides a yearly snapshot of staff experience at Ashford and St. Peter's Hospitals. Undertaken in October 2020, this year the survey had a dedicated section relating to COVID and how the experience had affected our staff. This survey together with feedback from our Staff Friends and Family Test, our real-time feedback tool: Peakon, our new Employee Recognition Scheme, and the feedback we get from engagement events such as Team Talk, provides us with evidence to understand the bigger picture, improve the working experience of colleagues and the corresponding experience for patients.

The National Staff Survey was completed by 1723 colleagues between Oct-Dec 2020. This is a response rate of 43%, which is just under the national average for Acute and Acute Community Trusts, at 45%.

a) Approach to staff engagement

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

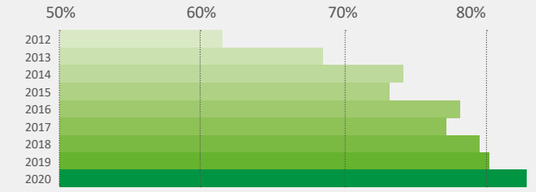
The Trust has a structured and regular communication process with our employees and their representatives including daily email bulletins, a weekly message from our Chief Executive, monthly blogs from executive colleagues and various formal and informal meetings with staff governors, our trade union colleagues, and other networks. We also have an organisational engagement mechanism 'Team Talk', which is run virtually on a fortnightly basis and is recorded so all staff can view even if they were not able to attend.

This year 'Team Talk' has been a critical way in which we were able to communicate with colleagues in real time regarding the operational status of the hospital and our response to managing the COVID pandemic.

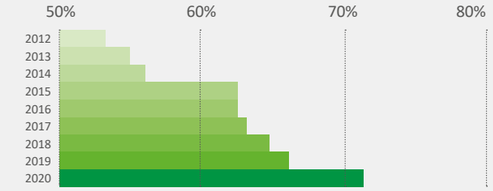
The staff engagement score that is measured in the annual survey is a helpful barometer for how staff are feeling. Over the past 8+ years, the Trust has been on an improvement trajectory and in 2020/21 this score improved again to 7.3/10, which is above the acute sector average.

Advocacy

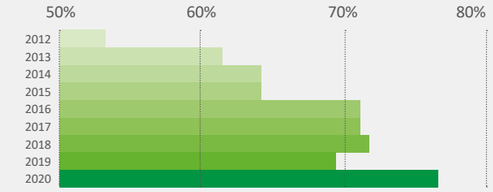
Care of patients/service users is organisation top priority



Would recommend organisation as a place to work

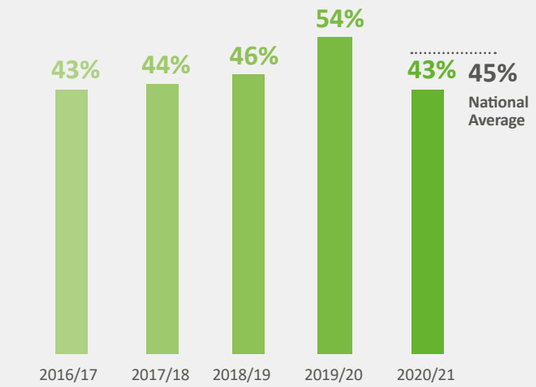


If friend/relative needed treatment, would be happy with standard of care provided by organisation



b) Summary of performance – results from the NHS staff survey 2020

Response Rate



Trust Improvement on last year and above the national average.

The following tables outline the Trust's performance against the ten main indicators for 2018, 2019 and 2020 and how they benchmark against other organisations in our benchmarking group.

	2020/2021		2019/2020		2018/2019	
	Trust	Benchmarking Group	**Trust**	Benchmarking Group	**Trust**	Benchmarking Group
Equality, Diversity and Inclusion	**8.9**	9.1	**8.9**	9.0	**8.9**	9.1
Health and Well-Being	**6.2**	6.1	**5.9**	5.9	**6.0**	5.9
Immediate Managers	**6.9**	6.8	**6.8**	6.8	**6.7**	6.7
Morale	**6.4**	6.2	**6.1**	6.1	**6.0**	6.1
Quality of Appraisals	**No available data**		**6.2**	5.6	**6.1**	5.4
Quality of Care	**7.7**	7.5	**7.5**	7.5	**7.5**	7.4
Safe Environment - Bullying and Harassment	**8.0**	8.1	**7.9**	7.9	**7.8**	7.9
Safe Environment - Violence	**9.5**	9.5	**9.4**	9.4	**9.4**	9.4
Safety Culture	**6.9**	6.8	**6.7**	6.7	**6.6**	6.6.
Staff Engagement	**7.3**	7.0	**7.2**	7.0	**7.2**	7.0
Team Working	**6.6**	6.5	**6.6**	6.6	**No available data**	

The national survey covers 10 key themes year on year. This year we were above average for seven themes, average on one and slightly below on two, Bullying and Harassment and EDI. This is an improvement on the 2019 results.

The Trust is keen to address the issues raised in the survey and other feedback mechanism and will be considering and acting on feedback to address concerns raised around bullying and harassment.

c) Future priorities and targets

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

The vision for the organisation is to a Great Place to Work, where we Listen, Empower and Value everyone, and this will continue to be our focus in the 2021/22 workforce transformation programme. Our objectives include creating a clear vision on how the Trust will be a great place to work and identifying ASPH unique selling point, clearly understanding what staff prioritise when choosing an employer and assessing our performance against this. We continued to develop our initiatives to address EDI priorities, to improve psychological safety, inclusion and kindness, and continuing a zero tolerance campaign regarding violence and aggression.

Throughout 2020/21, and to support our staff through the pandemic, we implemented a suite of tools to support staff with their emotional wellbeing. This included team based psychological support, training champions with regards to Emotional Health at Work, and Mental Health First Aid; training managers to have high quality wellbeing conversations, 1:1 psychological support, creating wobble rooms, and taking wellbeing initiatives with donations of food and beauty products to staff in their work environments.

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

1. **Improving Health and Wellbeing –** Health and wellbeing continues to be a key priority of the Trust and in 2021 we will be opening our new 'Wellbeing Hubs' for staff, which will include a space to exercise, socialise and relax, both indoors and outdoors.

Throughout the Pandemic we have ensure that our staff have a well-rounded offer to support their emotional wellbeing, and we are continuing to support them in the recovery phase of the pandemic. We have recruited a dedicated Wellbeing Officer and their initial focus will be on the physical wellbeing of staff, implementing interventions supporting exercise, health and nutrition. They will also lead on a number of wellbeing campaigns and support the launch of both a Men's and Women's Health Forum.

We will continue to develop interventions in all the areas of our wellbeing plan of Financial; Cultural; Social; Emotional; Physical and Environmental wellbeing.

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

Equality, Diversity and Inclusion

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

We are committed to building a diverse and well-supported workforce. We respect and value people's differences, enabling them to contribute and realise their full potential. We are proud of our diverse organisation with 38% of our staff from a Black, Asian and Minority (BAME) background. Our Lesbian, Gay, Bisexual, Trans, Queer/ Questioning and other identities (LGBTQ+) and BAME staff networks play a crucial role in contributing to and achieving diverse and inclusive organisation that meets the needs of patients and staff, raising awareness about EDI, and engaging in discussions with peers and Trust leaders. They give people the opportunity to engage in organisational decision making, which may otherwise not be possible and help us to create a more inclusive culture.

We recognise that there is a disproportionate experience for some colleagues, and our data illustrates that BAME colleagues are under-represented in senior leadership roles across a range of staff groups. It is also recognised that the COVID pandemic had a greater impact on our BAME workforce and communities, so this has become an opportunity to build strong foundations for collaboration and improvements to equality and tackle racial bias, inequalities, and discrimination. We need to move from segments of good practice, to a place where equality and inclusion conversations and considerations are mainstreamed across the organisation

The Trust offers comprehensive leadership and management development programmes aimed at every level, from those who take their first steps onto the management ladder to those stepping into senior leadership roles. These include the Stepping Up and Ready Now programmes offered by leadership academy and supported by the Trust, specifically aimed at BAME colleagues.

Our LGBTQ+ staff network launched the Ally training and Rainbow Badge campaigns last year. This has been incredibly successful already and will help raise awareness of the issues to support the Trust to become a more inclusive employer and create an inclusive environment for our patients

The COVID pandemic and Black Lives Matter campaign has brought race equality into sharper focus both for the NHS and the country. The Executive team have responded to this by prioritising participation in BAME network meetings and through collaborative development of the risk assessment.

Furthermore, the Black Lives Matter campaign mobilised support from all sections of the Trust workforce. This resulted in significantly increased support and membership of the BAME staff network, as well as a call to action to raise awareness and respond to issues relating to race. Several task force groups have been set up in order to do this.

Following recent feedback from BAME staff, the Freedom Speak Up BAME ambassadors programme was also launched to address the lack of BAME ambassadors. More work in this area is required to build confidence and trust in this service.

Last year we produced Managers' Guidance on Reasonable Adjustments with scenarios and examples to help with decision making. The implementation of reasonable adjustments was extended significantly during the pandemic to those staff who were identified as clinically or extremely clinically vulnerable.

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

NHS Foundation Trust Code of Governance

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

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

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

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code of Governance or, where it does not, to provide an explanation which justifies departure from the Code in particular circumstances. For the year ending 31 March 2021 the Trust complied with all the provisions of the Code of Governance published by NHS Improvement in 2014.

Board of Directors and the Council of Governors

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

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

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

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

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

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

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

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

.Composition of the Board

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

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

- **On 25 August 2020:** The Committee recommended the reappointment of the Chairman for a further three term and on the 15 February 2021 recommended the reappointment of Marcine Waterman, Deputy Chairman for a further three year term. On 30 September the Committee endorsed the interview panel's recommendation following consideration of the proposed Appointment Process for a new Non-Executive Director and Associate Non-Executive Director for subsequent ratification by the Council of Governors.

Introducing our Board of Directors

Andy Field, Chairman

Andy Field was appointed as Chairman from September 2017 and was re-appointed for a further three year term in September 2020.

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

As well as his role with us, Andy is Chairman of CSH Surrey, an employee owned social enterprises delivering a range of community services across Surrey and Think Learning, a business that implements Learning Management Systems. He is also a non-executive director of Customer Attuned which works in the business to business sector improving organisations' customer and partner relationships.

Dami Adedayo, Non-Executive Director

Dami obtained her MBBS and BSc Management from Imperial College London. She trained at hospitals in Surrey and London before qualifying as a GP and receiving her MRGCP. She was Chair of the Barnet Local Medical Committee for 5 years and a Director and Treasurer at London-wide Local Medical Committees and London-wide Enterprise Limited supporting and representing general practices across London before her appointment as Non-Executive Director in November 2020.

Dami is a member of the Quality of Care Committee, People Committee and Strategic Change Committee.

Professor Mike Baxter, Non-Executive Director

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

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

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

Mike stepped down as a Non-Executive Director in October 2020.

Jane Dale, Non-Executive Director

Jane was appointed in January 2020 and has an extensive and diverse background working within the NHS after joining in 1982 as a student nurse. After qualifying as a registered general nurse and then midwife, Jane worked in a variety of nursing roles before moving into management as a clinical governance manager for a primary care and community provider and commissioner. After this she was appointed Director of Clinical Care, responsible for pharmacy, primary care and community services.

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

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

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

Neil Hayward, Non-Executive Director

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

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

Chris Ketley, Non-Executive Director

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

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

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

Chris is Chair of the Integrated Digital Committee, a member of the Quality of Care Committee and Strategic Change Committee and sits on the Patient Experience Monitoring Group. In June 2020 he was appointed Co-Chair of the Joint Digital Assurance Committee for the Surrey Safecare ePR Programme for ASPH and Royal Surrey Foundation Trust.

Keith Malcouronne, Non-Executive Director

Appointed in July 2016, Keith has a background in accountancy and consultancy with KPMG, specialising in audit and corporate finance internationally. Since then, he has developed experience as a Private Sector/NGO Non-Executive Director, particularly with World Vision UK as Chairman of its Board Finance, Audit and Risk Committee. Keith has completed five years Chairman of TickX Limited and continues as an Audit and Corporate Finance Partner at the City firm Acuity Professional Partnership LLP.

Alongside his corporate and NGO responsibilities, Keith has board experience with several educational and Christian charities, including as a Non-Executive Director of the Guildford Diocesan Boards of Finance and Education.

Keith chairs the Audit and Risk Committee, is a member of both the Integrated Digital, Strategic Change and Charitable Funds Committees and sits on the North West Surrey End of Life Care Steering Group. Keith also serves as Non-Executive Lead for Freedom to Speak Up and Co-Chairman of the Surrey Safe Care Joint Digital Committee.

Meyrick Vevers, Non-Executive Director

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

Meyrick is a FCA (Fellow of the institute of chartered accountants) and is currently Finance Director of Datalec a company operating pan Europe on Data Centre Mechanical and Electrical fit outs. Aligned to his professional background Meyrick is also an experienced Non- Executive Director in both public and private sectors including being Chair of the Audit Committee for National Archives.

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

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

Marcine Waterman, Deputy Chairman

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

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

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

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

Arun Thiyagarajan, Associate Non-Executive Director

Arun qualified from Imperial College London with MBBS (Distinction) and BSc. He has also obtained his MRCP (UK), MRCGP (UK) and an MPH from The London School of Hygiene and Tropical Medicine. Lastly, he is close to completion of his Executive MBA from Imperial College Business School.

Arun is currently the Managing Director for BUPA UK's Health Clinics, having previously held the role of Medical Director. He is also the Responsible Officer for BUPA UK.

Arun is particularly passionate about digital innovation in patient pathways and has previously implemented successful technological step-changes in NHS GP practices across London and Oxford. He has held a National Institute for Health Research (NIHR) award which has culminated in published research focusing on the provision of synchronous video consultations in primary care. He also has multiple peer-reviewed publications ranging from sexual health to breast cancer. Previous experience outside of medicine and management also includes asset services analysis at Morgan Stanley.

Arun was appointed as Associate Non-Executive Director in November 2020.

Yvonne Obuaya, Associate Non-Executive Director

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

Her early career was in IT/Management Consultancy where she worked for multi-national companies including Eli Lilly and Rentokil. She then co-founded Curado in 2007, a residential mental health provider where she has collaborated with multiple Clinical Commissioning Groups NHS Trusts, Local Authorities and communities to establish, develop and transform adult community mental health and social care in the South East of England. Yvonne is currently Managing Director at Curado.

Yvonne completed her term as Associate Non-Executive Director in August 2020.

Suzanne Rankin, Chief Executive

Suzanne joined Ashford and St. Peter's in December 2010 as the Chief Nurse before securing the post of Chief Executive in September 2014.

Prior to joining the Trust, she held the post of Deputy Chief Nurse for NHS South Central where she worked across the region in the implementation of the Nursing and Midwifery Strategy as well as many clinical quality improvement and assurance initiatives.

Prior to that, Suzanne's nursing and management career was exclusively with the Royal Navy and included deployment during the 1990 Gulf War; a spell as Senior Nursing Officer at NATO HQ Lisbon and deployment to both Iraq and Afghanistan. Her final post with the Royal Navy was within the Surgeon General's Department at the Ministry of Defence.

Since appointment to the role of Chief Executive in 2014 Suzanne has focused on creating the "right culture" with Team ASPH enabling the delivery of the highest quality care and treatment. Suzanne and her team launched a new strategy for the organisation in 2018 the delivery of which is centred on a major transformation programme. The transformation of ASPH is orientated around 5 strategic initiatives which will require innovation, digitisation, standardisation and a focus on people and collaboration in order to be successful.

Suzanne is interested in the role that Ashford and St. Peter's has as an "anchor institution" a concept first developed in the US, that refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities. In pursuance of this role for the Trust Suzanne is working and developing relationships with a wide range of public, private and social entrepreneurial partners in health but also education, housing and business.

Most recently as part of the national response to the COVID Pandemic Suzanne was deployed in March 2020 to the Nightingale Hospital Programme and subsequently appointed to NHS Test and Trace as the National Director for C19 Containment prior to returning to the Trust in October.

Dr David Fluck, Medical Director

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

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

Andrea Lewis, Chief Nurse

Andrea Lewis was appointed as Chief Nurse in October 2020 having been interim Chief Nurse since December 2019.

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

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

Simon Marshall, Director of Finance and Information

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

Simon also is the Senior Responsible Officer for the Surrey Safe Care (Cerner EPR) Programme.

Louise McKenzie, Director of Workforce Transformation

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

In her time at Ashford and St. Peter's Hospitals she has worked closely with colleagues to improve the Trust resourcing and has a special interest in staff experience, morale, psychological safety and workforce wellbeing. Under Louise's leadership the Trust has won national Healthcare People Management Awards for two consecutive years in 2017 for Excellence in Employee Engagement, and 2018 for HR Working Smarter.

Louise is co-chair of the South Region HR Directors network working closely with regional and national colleagues from NHS Employers and NHS Improvement. She is a member of the Enterprise M3 Skills Advisory Panel, a group made up of chambers of commerce, university, higher education and local employment partners across Surrey and Hampshire, developing skills and talent to ensure economic growth in our local industries and sectors.

Tom Smerdon, Director of Strategy and Sustainability

Tom was appointed Director of Strategy and Sustainability in March 2019 and leads on strategy development and implementation, both internally at a Trust level and externally. His focus is on developing and transforming our services to deliver our strategic objectives in a sustainable way. This includes ensuring that ASPH services work effectively in an integrated health and care context and have a real impact on population health and wellbeing. Tom also holds executive responsibility for Estates and Facilities.

Tom was previously in the role of Director of Operations for Unplanned Care and has managed clinical operations in the NHS at a senior level since 2005. This experience has included managing elective, emergency and specialist services at UCLH and

Great Ormond Street Hospital. Tom joined Ashford and St. Peter's in 2013 as Associate Director of Operations for Medicine and Emergency Services.

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

James A Thomas, Chief Operating Officer

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

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

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

Faris Zakaria, Interim Medical Director

Zak is a Consultant Obstetrician and Gynaecologist who has worked in the Trust for over 20 years and who, prior to being seconded to the role of Acting Medical Director role in 2020, was the Divisional Director for Women's Health and Paediatrics. Zak's focus has always been aimed at delivering high quality care, upholding clinical standards and ensuring a safe service for patients and staff.

Zak provided exceptional clinical leadership of the staff COVID testing programme and the rapid and successful mobilisation of the COVID vaccine hub at St. Peter's Hospital. Following his secondment, Zak was appointed as Divisional Director for Specialist Surgery and iMSK services, where his focus is upon developing and embedding innovations as the key elements in restoration and recovery plans.

Significant Commitments of the Trust Chairman

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

Balance of Board Membership and Independence

The Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees. This conclusion is supported by the results of a skills audit of those in post at February 2021.

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

All Non-executive Directors, including the Chairman, have made declarations concerning their independence with the last annual review taking place in October 2020.

Performance evaluation

The Board of Directors recognises that a regular evaluation of its collective and individual director performance is critical to continuous development and high performance. During 2020/21 we have continued to build on the work previously identified in 2019/20 and further examined our development needs in order to collectively improve our performance.

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

Non-executive Directors. The appraisal of the Non-executive Directors is conducted by the Chairman in accordance with the process agreed by the Council of Governors. The Chief Executive undertakes the appraisal of the Executive Directors.

Chairman

The Senior Independent Director will conduct the Chairman's appraisal process in accordance with best practice in the code of governance, and this will be reported to the Council of Governors at their meeting in September 2021.

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

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

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

Access to the Register of Directors' Interests

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

Board meetings

The Board met in open session six times during 2020/21 and in closed session 11 times during 2020/21 Directors' attendance was as follows:

	End of term of office	Open Board Meetings attended	Closed Board Meetings attended
Non-Executive Directors			
Dami Adedayo*	November 2023	3 of 3	4 of 4
Prof Mike Baxter**	October 2020	3 of 3	6 of 7
Jane Dale	January 2023	6 of 6	11 of 11
Andy Field	September 2023	6 of 6	11 of 11
Chris Ketley	February 2022	6 of 6	11 of 11
Neil Hayward	July 2021	5 of 6	8 of 11
Keith Malcouronne	July 2021	6 of 6	11of 11
Yvonne Obuaya***	September 2020	2 of 2	5 of 5
Arun Thiyagarajan	November 2023	2 of 3	4 of 4
Meyrick Vevers	July 2022	6 of 6	11 of 11
Marcine Waterman	April 2021	6 of 6	11 of 11
Name	**End of term of office**	**Open Board Meetings attended**	**Closed Board Meetings attended**
Executive Directors			
Dr David Fluck****	Medical Director	6 of 6	9 of 11
Andrea Lewis	Chief Nurse	6 of 6	10 of 11
Simon Marshall	Director of Finance and Information	6 of 6	11 of 11
Louise McKenzie	Director of Workforce Transformation and Organisational Development	5 of 6	9 of 11
Suzanne Rankin***	Chief Executive	3 of 6	5 of 6
Tom Smerdon	Director of Strategy and Sustainability	6 of 6	9 of 11
James A Thomas	Chief Operating Officer	6 of 6	9 of 11
Faris Zakaria****	Acting Medical Director	1 of 2	2 of 4

* Dami Adedayo and Arun Thiyagarajan were appointed in November 2020

**Professor Mike Baxter left the Trust end October 2020

*** Yvonne Obuaya left the Trust in August 2020

**** David Fluck, Acting Chief Executive Jun-Oct 2020

***** Suzanne Rankin on secondment Jun-Oct 2020; attended Coroner's inquest in November

****** Faris Zakaria, Acting Medical Director Jun-Oct 2020

Nb: September Board moved to 1 October
March Board moved to 1 April

Board Sub Committees

The Board of Directors has the following sub committees:

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

Audit and Risk Committee

Membership and Attendance

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

Discharging its responsibilities

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

Policy for Safeguarding External Auditors' Independence

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

Responsibility for Preparing the Annual Accounts

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

Modern Healthcare Committee

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

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

Nominations Committee (Executive Directors)

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

The Committee is responsible for appointing Executive Directors including Interim appointments. The Committee is also responsible for ensuring that there is an appropriate

balance of skills, knowledge and experience on the Board of Directors, and this includes succession planning taking into account the challenges and opportunities facing the Trust.

Remuneration Committee (Executive Directors)

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

Quality of Care Committee

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

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

People Committee

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

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

Strategic Change Committee

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

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

Integrated Digital Committee

The Integrated Digital Committee is chaired by Non-Executive Director, Chris Ketley and membership comprises the Chairman and one other Non-Executive Director. Other members include the Chief Executive, Director Finance and Information, Medical Director, Chief Nurse, Chief Operating Officer and Director of Strategy and Sustainability. The committee's role is to provide assurance on the Trust's digital strategy, the prioritisation and development of its digital assets, programme of work and partnerships and to provide oversight of data quality and information security. It also has a role in ensuring staff education in the benefits that technology will bring and the changes needed in work practices and culture for its effective delivery. The committee also keeps under regular review the strategic risks for which it has responsibility.

Charitable Funds Committee

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

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

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

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

	Audit and Risk Committee	Remuneration Committee	Nominations Committee	Quality of Care Committee	People Committee	Modern Healthcare Committee	Integrated Digital Committee	Strategic Change Committee	Charitable Funds Committee	Council of Governors (in attendance)
Dami Adedayo*#	n/a	n/a	n/a	1/3	2 of 3	n/a	n/a	1 of 1	n/a	2 of 2
Mike Baxter**	n/a	n/a	n/a	3 of 3	4 of 4	n/a	n/a	1 of 2	n/a	1 of 3
Jane Dale	n/a	n/a	n/a	7 of 7	7 of 7	n/a	n/a	3 of 3	n/a	3 of 3
Andy Field	n/a	3 of 3	2 of 2	n/a	n/a	n/a	5 of 5	3 of 3	3 of 3	3 of 3
David Fluck***	n/a	n/a	1 of 1	5 of 7	5 of 7	5 of 7	2 of 5	3 of 3	n/a	3 of 3
Neil Hayward	n/a	2 of 3	2 of 2	n/a	7 of 7	7 of 9	n/a	3 of 3	n/a	1 of 3
Chris Ketley	n/a	n/a	n/a	7 of 7	n/a	n/a	5 of 5	3 of 3	n/a	2 of 3
Andrea Lewis	n/a	n/a	n/a	7 of 7	5 of 7	n/a	2 of 5	3 of 3	n/a	3 of 3
Keith Malcouronne	4 of 4	n/a	n/a	n/a	n/a	n/a	5 of 5	3 of 3	3 of 3	3 of 3
Simon Marshall	n/a	n/a	n/a	n/a	n/a	9 of 9	4 of 5	3 of 3	3 of 3	3 of 3
Louise McKenzie	n/a	n/a	n/a	n/a	7 of 7	n/a	1 of 1	3 of 3	n/a	3 of 3
Yvonne Obuaya****	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1 of 1	n/a	3 of 3
Suzanne Rankin***	n/a	n/a	n/a	4 of 4	5 of 5	n/a	n/a	0 of 1	n/a	2 of 2
Arun Thiyagarajan*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1 of 1	n/a	2 of 2
James A Thomas	n/a	n/a	n/a	6 of 7	5 of 7	9 of 9	4 of 5	2 of 3	n/a	3 of 3
Meyrick Vevers	4 of 4	3 of 3	2 of 2	n/a	n/a	9 of 9	n/a	3 of 3	3 of 3	3 of 3
Marcine Waterman	4 of 4	3 of 3	2 of 2	7 of 7	7 of 7	9 of 9	n/a	3 of 3	n/a	2 of 3
Tom Smerdon ******	n/a	n/a	n/a	n/a	3 of 6	6 of 9	4 of 5	3 of 3	n/a	2 of 3
Faris Zakaria******	n/a	n/a	n/a	n/a	2 of 2	n/a	n/a	1 of 1	n/a	0 of 1

Notes

1. * Dami Adedayo and Arun Thiyagarajan were appointed in November 2020
2. ** Professor Mike Baxter left the Trust end October 2020
3. *** David Fluck, Acting Chief Executive Jun-Oct 2020
4. **** Yvonne Obuaya left the Trust in September 2020
5. ***** Suzanne Rankin on secondment Jun-Oct 2020
6. ****** Tom Smerdon, Director of Strategy & Sustainability joined People in July 2020
7. ******* Faris Zakaria, Acting Medical Director Jun-Oct 2020

Dami Adedayo – March 2021 Quality of Care/People Committee: this was authorised absence due to attending Non-Executive Director Induction

Council of Governors

How the Board of Directors and the Council of Governors operate

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

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

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

Understanding the views of the Council and Members

Engagement by the Board with Governors takes many forms. In 2020/21 the constructive working relationship has continued with discussion on a number of matters both in and out of Council meetings. As well as the quarterly Council meetings the Board and Governors also meet twice a year to discuss strategic issues and input into the Trust business plan. The Governors also have four dedicated meetings with the Non-Executive Directors to discuss Trust business and anything they would like further input on.

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

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

Composition of the Council

There are 25 seats on the Council of Governors including:

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

The Chairman of the Board is also the Chairman of the Council of Governors. The Council of Governors reappointed Danny Sparkes (Public Governor for Runnymede, Surrey Heath and Windsor and Maidenhead) as the Lead Governor in December 2020.

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

There were no Council of Governor elections held in 2020.

The Council lost a much respected member of the Council during 2021- Roberta Swan, who sadly passed away in January 2021.

The Council would also like to thank Cllr Maureen Attewell for five years as Appointed Governor from Spelthorne Borough Council and welcomes Cllr Rose Chandler as her replacement.

Access to the Register of Interests

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

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

Contacting a Governor

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

Statutory Council of Governors' Committees

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

Nomination and Appointments Committee

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

The Committee met three times during 2020/21 recommending to the Council:

- The proposed Non-Executive Director appointment process
- The appointment of two Non-Executive Directors
- The re-appointment of the Chairman
- The re-appointment of a Non-Executive Director

Nominations and Appointments Committee	Meetings attended
Neal Adolphus (Public Governor for Spelthorne)	3 of 3
David Carpenter (Public Governor for Elmbridge)	1 of 3
Andy Field (Trust and Committee Chairman)	3 of 3
Chris Howorth (Appointed Governor for the Royal Holloway, University of London)	3 of 3
Julian Ruse (Staff Governor for Administrative and Clerical, Managerial and Ancillary staff)	3 of 3
Michael Smith (Public Governor for Woking and Guildford)	3 of 3

Remuneration and Appraisal Committee

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

The Committee met four times during 2020/21 recommending to the Council:

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

Membership and attendance is given below:

Remuneration and Appraisal Committee	Meetings attended
Lilly Evans (Public Governor for Runnymede, Surrey Heath, Windsor and Maidenhead)	4 of 4
Shirley Holmes (Public Governor for Woking and Guildford)	3 of 4
Deborah Hughes (Appointed Governor from Woking Borough Council	3 of 4
Danny Sparkes (Lead Governor and Public Governor – Runnymede, Surrey Heath, Windsor and Maidenhead)	4 of 4
Matt Stevenson (Staff Governor- Allied Health Professionals, Healthcare Scientists and Healthcare Assistants)	4 of 4

Foundation Trust membership

Members fall into two constituencies:

Public Constituency; anyone living in the boroughs of Elmbridge, Guildford, Hounslow, Kingston-upon-Thames, Richmond-upon-Thames, Runnymede, Spelthorne, Surrey Heath, Windsor and Maidenhead and Woking; as well as any borough in Surrey not already mentioned above, can become a member. In October 2020 the Council of Governors agreed to have a Rest of England constituency which would incorporate the previous Rest of Surrey constituency and allow for members that resided in areas outside the Trust's immediate catchment area.

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

1. Nursing and midwifery

2. Medical and dental

3. Ancillary, administrative, clerical and managerial

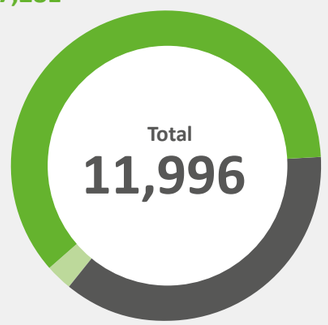
4. Allied health professionals, healthcare scientists and healthcare assistants

5. Volunteers

Staff are automatically members unless they decide to opt out.

Membership numbers as at 31 March 2021

Public 61%
7,281



Volunteers 2%
303

Staff 37%
4,412

Developing our membership

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

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

In addressing these priorities, the Trust continues to be mindful of hard to reach groups. Before COVID and the lockdown, it was possible to attend a careers' fair at Ashford Hospital and many students and job seekers wishing to pursue a career in the NHS were encouraged to become a member. The Group has been keen to encourage membership engagement activities and also considers ways of facilitating two way communications with members. Surveys have been utilised in the past and will continue to feature.

Feedback is encouraged through the Governor Contact form on the Trust's website and via personal communications either written or spoken. The Trust holds a number of Members' Health Events throughout the year which provide a presentation and question and answer session on a number of health-related topics. Events were curtained during 2020/21 due to COVID but the Annual Members' Meeting went ahead and took place virtually. Health events are extremely popular with members and the Trust receives positive feedback on the content and the opportunity it provides for members to converse with Governors. It is hoped that these will resume in the near future.

Feedback is also welcomed and discussed by Governors who are members of the Patient Experience Group. The Group meets five times a year and the Head of Patient Experience and Involvement/Associate Director of Quality is invited to attend to report on patient experience and also to enable issues and concerns to be raised and appropriate actions taken.

Since the pandemic, meetings have continued virtually. The Group usually visits departments and wards and meets senior clinical and nurse managers in order to be more effective in sharing the improvement of the patient experience. The Group was fortunate to be able to undertake a guided tour of the new Infusion Suite at Ashford Hospital before the lockdown. Since the pandemic department heads have been invited to attend virtual meetings to share the work they are undertaking.

Register of Council of Governors - 2020

Name (Constituency / Organisation)	Date elected or appointed	Term of office	Meetings attended
Edwin Addis (Public – Hounslow, Kingston-upon-Thames and Richmond-upon-Thames)	1st Dec 2019	3 years to 30/11/22	4 of 4
Neal Adolphus (Public – Spelthorne)	1st Dec 2019	3 years to 30/11/22	3 of 4
Miranda Alcock (Public – Woking and Guildford)	1st Dec 2019	3 years to 30/11/22	3 of 4
Tom Allan (Staff Governor – Volunteers)	1st Dec 2018	3 years to 30/11/21	4 of 4
Maureen Attewell (Appointed – Spelthorne Borough Council)	9th July 2015	5 years to 30/06/20	0 of 1
Derek Barnes (Public – Spelthorne)	1st Dec 2019	3 years to 30/11/22	3 of 4
Tracey Bradshaw (Staff – Nursing and Midwifery)	1st Dec 2019	3 years to 30/11/22	3 of 4
David Carpenter (Public – Elmbridge)	1 Dec 2019 (2nd term)	3 years to 30/11/22	2 of 4
Rose Chandler (Appointed – Spelthorne Borough Council)	15th July 2020	N/A	3 of 3
Iftikhar Chaudhri (Appointed – Runnymede Borough Council)	1st Dec 2018	N/A	3 of 4
Melaine Coward (Appointed – University of Surrey)	1st Mar 2017	N/A	2 of 4
Lilly Evans (Public – Runnymede, Surrey Heath and Windsor and Maidenhead)	1st Dec 2018 (2nd term)	3 years to 30/11/21	4 of 4
Oscar Garcia-Casas (Staff – Medical and Dental)	1st Dec 2018	3 years to 30/11/21	1 of 4
Shirley Holmes (Public – Woking and Guildford)	1st Dec 2019	3 years to 30/11/22	4 of 4
Colin Hood (Public – Spelthorne)	1st Dec 2019	3 years to 30/11/22	4 of 4
Chris Howorth (Appointed – Royal Holloway, University of London)	1st Dec 2010	N/A	3 of 4
Deborah Hughes (Appointed – Woking Borough Council)	23rd May 2018	N/A	4 of 4
Hina Malik (Public – Hounslow, Kingston-upon-Thames and Richmond-upon-Thames)	1st Dec 2019	3 years to 30/11/22	2 of 4
Chris Marks (Public – Runnymede, Surrey Heath, Windsor and Maidenhead)	1st Dec 2018	3 years to 30/11/21	3 of 4
Sinead Mooney (Appointed – Surrey County Council)	1st Aug 2018	2 years 8 months to 4/05/21	1 of 4
Helen Pernelet (Public – Elmbridge)	1st Dec 2019	3 years to 30/11/22	3 of 4
Julian Ruse (Staff – Administrative and Clerical, Managerial and Ancillary)	1st Dec 2018	3 years to 30/11/21	4 of 4
Michael Smith (Public – Woking and Guildford)	1st Dec 2019	3 years to 30/11/22	4 of 4
Danny Sparkes (Public – Runnymede, Surrey Heath and Windsor and Maidenhead)	1st Dec 2018 (3rd term)	3 years to 30/11/21	4 of 4
Matthew Stevenson (Staff – Allied Health Professionals, Healthcare Scientists)	1st Dec 2019 (2nd term)	3 years to 30/11/22	4 of 4
Roberta Swan (Public – Elmbridge)	1st Dec 2019 (2nd term)	3 years to 29/01/21	2 of 4

NHS Oversight Framework

NHS Improvement is the official regulator of Foundation Trusts.

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

The framework looks at five themes:

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

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

Segmentation

The Trust has a segmentation rating of '2'.

This segmentation information is the Trust's position at 6 May 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Sustainability Report

ASPH remains committed to our Anchor organisation principles, understanding the impact we can have on the communities around us. This includes our responsibility to deliver positive environmental impact.

Despite the huge pressures on staff responding to the pandemic, ASPH has continued to consider ways to reduce waste and energy consumption, improve our green spaces and bring social value into how we conduct business.

Emissions and air quality

All ASPH vehicles are now a minimum EURO 6 engine compliant resulting in an estimated 10 tonne reduction in carbon emissions per year compared to 2019. Free staff travel on the White-Bus from Woking to St. Peter's initiated last year has continued, enabling staff to leave their cars at home and maintain the reduced emissions this achieved last year. A significant number of outpatient appointments became 'virtual' during the pandemic, being conducted by telephone or video. This saves patients a journey and evaluation has shown an average saving of 600g of emissions per appointment taking place virtually.

By April 2021, ASPH delivered nearly 50% of all OPD appointments virtually, equating to approx. 4.5 tonnes of emissions saved per week through less patient journeys. To encourage staff to use their bicycles a Bicycle User Group (BUG) has been re-established to encourage more to cycle to work with improved storage and security for bicycles on site and working with the council on improving cycle routes.

Waste and recycling

A Waste Action Group (WAG) has been established where staff are learning from around the country to identifying ways the trust could reduce the amount of waste we produce, and increase the proportion of our waste that is recycled or re-used. Reducing single use plastics is a priority area, building on the NHS Single Use Plastics Pledge we signed in 2019/20. There has been a national increase in plastic use with PPE and other infection control protocols during the pandemic to keep patients and staff safe. However, ASPH facilities team have made a significant contribution to reducing single-use plastics by converting to non-plastic disposable cutlery resulting in an 85% reduction of plastic cutlery purchases this year. Trust catering outlets now use only degradable takeaway containers to reduce plastic waste further.

10 TONNES

REDUCTION IN CARBON EMISSIONS PER YEAR COMPARED TO 2019.

CO_2

600g

EMISSIONS SAVED PER VIRTUAL APPOINTMENT

Our total waste of all kinds dropped by 1.5% (21 tonnes) from 2019/20 to 2020/21, despite all the extra PPE waste created. Waste requiring special disposal (clinical and infected waste) increased by 2.4% (17 tonnes), whilst black bag waste reduced by 7% (43 tonnes), and recycling increased by 5 tonnes. This means that in 2019/20 14% of non-clinical waste was recycled, which increased in 2020 to 16%.

The WAG is initiating new projects to reduce the quantity of plastic gloves used (currently at 25,000 pairs per day) and to secure methods for collecting and recycling plastics with local community partners for 2021.

Bring Nature to Sites

Evidence shows the benefit of green spaces for wellbeing and for air quality. Initially postponed during the pandemic, since Christmas a comprehensive programme of developing our green spaces has begun to provide outside seating, plant trees, shrubs and flowers to encourage nature and cleaner air.

Future ambitions

As our services and teams recover from a challenging year there is a rejuvenated passion for action in 2021/22 to demonstrate impacts in five priority areas:

- Reducing emissions towards net zero carbon
- Reduce total amount of waste we produce
- Increase the proportion of our waste that is recycled
- Reduce plastic waste
- Develop calming outside spaces with tree planting to improve air quality and wellbeing

A COMPREHENSIVE PROGRAMME OF DEVELOPING OUR GREEN SPACES HAS BEGUN TO PROVIDE OUTSIDE SEATING, PLANT TREES, SHRUBS AND FLOWERS TO ENCOURAGE NATURE AND CLEANER AIR.

Statement of Accounting Officer's Responsibilities

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

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

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

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

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

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

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. This included a comprehensive handover of governance arrangements before and following my secondment (June to October 2020) with Dr David Fluck who undertook the role of role as Acting Chief Executive and Accounting Officer during this time.

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

Suzanne Rankin
Chief Executive

10 June 2021

Annual Governance Statement 2020/21

Scope of responsibility

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

The purpose of the system of internal control

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

Capacity to handle risk

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

The risk and control framework

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

Risk Management

The Trust's approach to risk for the year 2020/21 is detailed in the Risk Management Strategy and sets out our systematic approach to achieving effective enterprise risk management strategically, operationally and culturally. We aim for all our staff to understand and act proactively so that we maximise our success going forward and minimise things going wrong for our patients, staff and stakeholders. Senior managers and Directors are trained in risk management on joining the organisation and subsequently in accordance with the Trust's Mandatory Training Policy.This strategy aligns with the 2018 Trust Strategy.

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

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

The Board Assurance Framework is reviewed at each meeting of the Audit and Risk Committee.

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

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

Key Issues and Risks

During 2020/21 each sub-committee has undertaken a continuous process of re-assessing and redefining the key risks associated with the Strategic Objective for which the committee has responsibility to deliver. These risks comprise the Board Assurance Framework, which takes into account both external and internal factors and uncertainties, and forms part of our risk management process.

The mitigating actions for each of the strategic risks detailed below have Executive Director ownership and are presented to each Board sub-committee meeting for oversight and scrutiny. Each Board sub-committee also scrutinises the Key Performance Indicators (KPIs) associated with each strategic risk for which it has oversight, in order to better understand how well the risks are being mitigated and to measure the progress towards achieving the strategic objectives and Trust Strategy overall.

In turn, the risks, associated Key Performance Indicators and the assurances upon mitigating actions received at each Board sub-committee form the basis of the Chief Executive's Risk Summary report to each open Board meeting.

Strategic Objective: Quality of care

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

Strategic Objective: Modern healthcare

2.1	Inability to live within the new financial framework envelopes (when announced) due to the likely requirements to run elective work during winter, undertake or outsource additional catch up activity, whilst reconfiguring / expanding bed, diagnostic and outpatient capacity, and given existing staffing constraints.
2.2	A failure to maintain the Trust's physical environment and clinical infrastructure, may lead to clinical pathway difficulties, deteriorating patient and staff experience, patient safety, and health and safety risks.
2.3	A failure to deliver constitutional and operational targets leading to increased patient delay, poor patient experience, increased patient safety risks, increased outsourcing or activity and corresponding loss in productivity/efficiency.
2.4	The myriad of changes to operational arrangements, supply/demand, social distancing requirements and increased staff absence from COVID may have substantial impacts on our previous productivity/efficiency and financial standing.
2.5	Potential external impacts from the Surrey Heartlands ICS overall financial, activity level, and waiting list positions as well as requirements for mutual aid.

Strategic Objective: People

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

Strategic Objective: Collaborate

5.1	Insufficient capability and capacity to deliver the strategy programme (i.e. the strategic objectives) in accordance with the operating plan so that effect is diminished and/or service sustainability is significantly challenged.
5.2	External factors such as decisions taken by national, ICS, ICP impact our delivery or attempt to counter our objectives or undermine our service sustainability.
5.3	Ineffective oversight of the strategy may result in the desired effect and intended benefits to quality and sustainability of patient care not being realised.
5.4	Ineffective or insufficient focus on stakeholder management may result in effective external relationships not being sustained.

Corporate Governance Statement

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

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

Performance monitoring

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

Data quality and information security updated

The Data Security and Protection Toolkit18 (DSPT) enables NHS organisations to self-assess against the National Data Guardian's 10 data security standards to provide assurance that they are implementing good data security, and that personal information is handled correctly. The Trust's assessment for 2020/21 would normally have been submitted by 31 March 2021.

However, in light of continuing events, NHSX has recognised that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID response. NHSX has therefore taken the decision to push back the final deadline for DSPT submissions to 30 June 2021. The Trust has therefore decided to defer its DSPT submission until this date and is expected to achieve a status of "Standards Met". Progress with the DSPT is monitored throughout the year by the Information Governance Steering Group. The annual mandatory internal audit of the DSPT has been carried out and the report is being finalised.

CQC compliance

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

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

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

During 2020/21 the CQC inspection regime has been suspended due to the COVID pandemic. Currently, there is no planned inspection of the Trust and there have been no targeted inspections during 2020/21. The Trust attends monthly engagement meetings with the CQC in order to provide assurance overall and to address any emergent issues of concern.

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

Register of Interests

The Trust has published on its website an up to date register of interests for Trust Board members as required by the Managing Conflicts of Interest in the NHS guidance.

NHS Pension Scheme

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

Equality, diversity and human rights legislation

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

Climate Change

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

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

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

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

Each Division has a Divisional Director, who is a clinician and is actively involved in the business and devolved financial management of clinical services. Divisional scorecards are used to assess each Divisions performance at a specialty and ward level. Monthly Executive-Divisional review meetings are held with each division, a forum in which all aspects of performance are reviewed.

The Trust has continued to produce Service Line Reporting (SLR) and Patient Level Costing data during the year although the use of this by divisional teams was impacted upon by the COVID pandemic. All COVID additional expenditure was reviewed in real time by the Director of Finance and Information and retrospectively by the Modern Healthcare Committee to ensure it was in line with national requirements.

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

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

Information Governance

Information Governance Assessment

The Data Security and Protection Toolkit (DSPT) enables NHS organisations to self-assess against the National Data Guardian's 10 data security standards to provide assurance that they are implementing good data security, and that personal information is handled correctly.

Data Security and Protection Toolkit Self-Assessment Outcome

The submission date for 2020/21 DSP Toolkit has been extended from 31st March 2021 to June 2021 in order to enable organisations to focus on their COVID response.

The Trust has now completed its annual internal audit of the Toolkit, the final report should be available by the end of May. The Trust is on track to achieve all required standards and submit Standards Met status.

Information governance personal data breaches (including data losses)

All Trust staff have a duty to report incidents such as breaches of confidentiality, however minor, so that lessons can be identified and used to inform future practice. All information- related incidents reported in 2020/21 were assessed in accordance with NHS Digital's guidance:[4]

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

Grading the personal data breach

All incidents are graded according to the significance of the breach and the likelihood of those serious consequences occurring. The DSP Toolkit reporting tool is used for significant incidents and any above a certain grade are reportable to the Information Commissioner's office and the Department of Health and Social Care, with the most significant requiring notification within 24 hours.

Reported breaches

Breaches from 2020/21 are reported below:

Breaches reported on to DATIX	94
Breaches reported on to the DSP Toolkit (since 1st April 2020)	3
Breaches reported to the ICO (via the DSP Toolkit)	2

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

Incidents reported to the Information Commissioner's Office

The Trust reported 2 incidents to the Information Commissioner's Office:

Date of incident (month)	September 2020
Nature of incident	Staff inappropriately accessing information systems/records
Nature of data involved	A member of staff inappropriately accessed the records of three patients and disclosed confidential information regarding a fourth to a third party. This came to light following two separate complaints received by the Trust.
Number of data subjects potentially affected	4 (initially 2 were identified)
Notification steps	On receipt of the initial complaint, the ICO was notified – response below. An investigation was carried out and disciplinary procedures were followed. Internal discussions are ongoing with reference to the ICO's recommendations regarding procedures, training and contract clauses. The case has (anonymously) been referred to as an example during recent confidentiality discussions at the Trust Executive Committee, with a formal paper to be presented in due course in order to further highlight the importance of preserving patient confidentiality as a matter of routine.
Information Commissioner's Office (ICO) recommendations	On 17 October 2020, the ICO responded with the following: **Data security requirements** You are required to have appropriate technical and organisational measures in place to ensure the security of personal data. **Our Decision** We have considered the information you have provided, and we have decided that no further action by the ICO is necessary on this occasion. This decision is based on the information we have recorded about the breach. As part of this decision we consider the detriment caused in instances where loss or harm, or upset and anguish, over and above annoyance level, has been suffered by individuals who are the subject and the focus of the information. The reasons for our decision are as follows: • Our criminal investigation team have considered the information you have provided and do not consider there to be enough evidence to substantiate a criminal offence at this time • The incident is limited to two data subjects • Although the personal data has the potential to cause detriment, at this stage there appears to be no clear evidence of serious harm • Once aware of the potential breach, suitable steps have been taken to examine the root cause and to mitigate the impact from it • Your inquiry has confirmed that the information is not on Facebook. At this stage, this is an allegation by one of the data subjects • You advise that appropriate measures were place to keep personal data secure. It appears the staff member responsible had legitimate access. However, they then went against protocol and looked at records for two patients who were not in their care • To help prevent a recurrence, a suitable internal investigation is on-going, and a disciplinary is planned in due course • This seems to be an isolated incident, rather than a broader systemic failure However, we recommend that you investigate the causes of this incident to ensure that you understand how and why it occurred, and what steps you need to take to prevent it from happening again. **In particular, we recommend that you consider:** • Continuing with your investigation into the incident and disciplinary process. If you would like us to review the case following their conclusion, please forward the outcome to us, quoting the above case reference number • If not already doing so ensuring you have procedures and training in place that make it clear to all levels of staff what they can and cannot do with the personal data they use. You should also consider including employment restrictive covenant clauses in employment contracts to clarify who controls the personal information and to set requirements as to what happens when employees leave the organisation

Incidents reported to the Information Commissioner's Office

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

Date of incident (month)	March 2021
Nature of incident	Lost or stolen paperwork
Nature of data involved	Contracted courier service contacted the Trust to disclose that on the way to another NHS provider, a tissue sample and corresponding patient's documentation were lost.
Number of data subjects potentially affected	1
Notification steps	ICO notified, awaiting response. The Trust has asked the courier company to investigate this incident; the company have confirmed that two couriers retraced the original journey in order to locate the missing box but to no avail. The Police were contacted in order to allow viewing of any CCTV of the courier's journey, again with no result. The courier has changed their box and the way it fits to the bike and a full apology has been provided. The Trust is reviewing the contract in place with the courier.
Information Commissioner's Office (ICO) recommendations:	Acknowledgement of the self-referral was received from the ICO on 06/04/2021; full response pending.

Data quality and governance

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

As with the previous year (2019/20), in order to enable providers to focus upon the COVID response, NHSE and NHSI have removed the requirement for Trusts to include a quality report section in this Annual Report nor is an external limited assurance report required. The Trust has however, produced its Annual Quality Account which will be available on the Trust website following submission to NHSE and NHSI on 30 June 2021.

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

A range of other reports and dashboards enable the Trust Board to monitor performance and outcomes. The Board Assurance Framework KPI dashboard provides high level summary on key targets aligned to the five strategic objectives, quality of care, people, and modern healthcare, digital and collaborate. CHKS healthcare intelligence[3] services also enable clinicians to access key quality and performance data for their speciality.

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

[3] CHKS Limited, as part of Capita PLC

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. However, as a result of the ongoing pandemic, the external auditors were allowed by the NAO to prioritise their audits of the financial statements and to delay their work on Value For Money arrangements until no later than September 2021. We note that Mazars LLP had not completed their work on Value for Money due to their internal resourcing and delivery issues at the time of signing our financial statements opinion. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and the Quality of Care Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

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

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

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

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

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

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

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

Internal Audit: BDO LLP are the Trust's providers of internal audit services since June 2017. The contract specifies that the delivery of the internal audit function will continue to be in compliance with Public Sector Internal Audit Standards

The annual opinion given by the Head of Internal Audit for 2020/21 provided moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

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

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

A&E: Like many providers across England, the Trust struggled with the A&E four hour waiting target throughout the year recording a total of 87.4% (NHSI) for the full year and 94.3%, 90.8%, 83.0% and 83.3% respectively for the four quarters of the year.

The impact of the COVID pandemic and respective national lockdowns created highly fluctuating attendance levels on both a daily and monthly basis. To ensure patients and staff remained safe during a very uncertain time regarding transmissibility and mortality of the virus, the Trust created two separate emergency departments (one for COVID and one for non- COVID patients) albeit increasing pressure on an already compressed site.

Despite the above measures, the Trust recorded almost compliant performance during Q1 due to the reduced levels of ED attendance within the department and excellent flow into the wards due to low Trust bed occupancy at that time.

Since this time the Trust has seen varied performance levels mainly due to the high occupancy and restricted availability of Trust beds causing slow flow from ED to wards and restricted space within ED keeping separate ' COVID' and 'non COVID' patient flows.

RTT: The Trust started the year with an improving RTT performance until the COVID pandemic; although then saw deterioration in performance during the first half of the year when, during the first wave of the pandemic, the Trust was asked by NHSE/I to halt elective surgery to ensure sufficient beds and staffing were available to care for the surge in COVID inpatients. Good improvement was seen during Q3 although this was then impacted during the substantial surge received in COVID inpatients during
Q4 and the requirement to once again pause most elective surgery.

The Trust's annual RTT position was recorded at 77.1%, with improvement seen during Q4 to 79.2%. This level of performance, whilst falling lower than the national target of 92%, remains favourable against the average England performance of 61.7% for the year.

The Trust has resolute plans to improve RTT performance during 2021/22 ensuring patients are treated in clinical and chronological order. Furthermore, the Trust's performance in emergence from the COVID pandemic has placed a number of the Trust's specialties within the top 10 for RTT performance across England (with 10,000+ patients on their waiting list) including a low number of patients waiting over 52 weeks for treatment.

Cancer: The Trust received over 17,000 urgent cancer referrals during the year, an overall 7.5% decrease compared to the previous year, (25% increase over the previous 3 year period). The Trust provided full referral, diagnostic and treatment facilities for clinically urgent, risk assessed procedures for cancer patients during the COVID pandemic and continues to work with our commissioners at Surrey Heartlands CCG to support delivery of compliant performance.

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

Conclusion

I am reporting two significant control issues within the Foundation Trust, being failure to meet the four hour waiting time target and non-compliance with RTT targets in 2020/21.

Suzanne Rankin
Chief Executive

10 June 2021

4. ANNUAL ACCOUNTS

5. Annual Accounts

1 April 2020 – 31 March 2021

Foreword to the Accounts

These Accounts for the year ended 31 March 2021 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4)(a) of the National Health Service Act 2006.

Suzanne Rankin
Accounting Officer
Ashford and St. Peter's Hospitals NHS Foundation Trust
10 June 2021

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

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of Ashford & St Peters Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2021 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity , the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on 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.

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

Other information

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

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

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

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

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. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer'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 posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit & Risk Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and Audit & Risk Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and Audit & Risk Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accounting Officer

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

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

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

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21; and

- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

In our opinion:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2020/21; or

- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or

- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or

- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Lucy Nutley
Lucy Nutley - Key Audit Partner
For and on behalf of Mazars LLP

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

15 June 2021

Audit Completion Certificate issued to the Council of Governors of Ashford & St Peters Hospitals NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 15 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 15 June 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

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

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in this respect.

Certificate

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

Lucy Nutley - Key Audit Partner
For and on behalf of Mazars LLP

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

7 September 2021

Statement of Comprehensive Income for the year ended 31 March 2021

	Note	2020/21 £'000	2019/20 £'000
Income			
Income from patient care activities	3	336,552	312,242
Other operating income	4	50,720	31,200
Operating expenses	5	(385,095)	(336,139)
Operating surplus		**2,177**	**7,303**
Finance costs			
Finance income	11	-	358
Finance expense	12	(265)	(339)
Public dividend capital dividends payable		(5,568)	(6,135)
Other gains/(losses)	13	(2)	-
Retained (deficit)/surplus for the year		**(3,658)**	**1,187**
Other Comprehensive Income			
Impairments – net reversal on property, plant and equipment		(7,717)	(12,278)
Revaluations		10	147
Total comprehensive (expense)/income for the year		**(11,365)**	**(10,944)**

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

Statement of Financial Position as at 31 March 2021

	Note	31/03/21 £'000	31/03/20 £'000
Non-current assets			
Property, plant and equipment	14	204,729	185,471
Intangible assets	15	5,160	5,462
Other investments	18	60	60
Receivables	20	936	7,320
Total non-current assets		**210,885**	**198,313**
Current assets			
Inventories	19	4,109	3,773
Receivables	20	19,079	34,448
Cash and cash equivalents	21	76,580	53,470
Total current assets		**99,768**	**91,691**
Total assets		**310,653**	**290,004**
Current liabilities			
Trade and other payables	22	(49,744)	(35,898)
Other liabilities	22	(1,457)	(293)
Borrowings	23	(1,921)	(1,828)
Provisions	25	(2,090)	(1,526)
Total current liabilities		**(55,212)**	**(39,545)**
Total assets less current liabilities		**255,441**	**250,459**
Non-current liabilities			
Borrowings	23	(3,758)	(4,885)
Provisions	25	(871)	(336)
Total assets employed		**250,812**	**245,238**
Financed by taxpayers' equity			
Public dividend capital		110,070	93,131
Income and expenditure reserve		83,249	86,907
Revaluation reserve		57,493	65,200
Total taxpayers' equity		**250,812**	**245,238**

The financial statements on pages 128 to 173 were approved by the Board on 10 June 2021 and signed on its behalf by:

Suzanne Rankin,
Accounting Officer

10 June 2021

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

	Public Dividend Capital (PDC) £'000	Retained Earnings £'000	Revaluation Reserve £'000	Total £'000
Changes in taxpayers equity for the year ended 31 March 2021				
Balance at 1 April 2020	93,131	86,907	65,200	245,238
Retained surplus/(deficit) for the year	-	(3,658)	-	(3,658)
Public Dividend Capital received	16,939	-	-	16,939
Net impairments	-	-	(7,717)	(7,717)
Net gain in revaluation of property, plant and equipment	-	-	10	10
Balance at 31 March 2021	**110,070**	**83,249**	**57,493**	**250,812**
Changes in taxpayers equity for the year ended 31 March 2020				
Balance at 1 April 2019	88,975	85,720	77,331	252,026
Retained surplus/(deficit) for the year	-	1,187	-	1,187
Public Dividend Capital received	4,156	-	-	4,156
Net impairments	-	-	(12,278)	(12,278)
Net gain in revaluation of property, plant and equipment			147	147
Balance at 31 March 2020	**93,131**	**86,907**	**65,200**	**245,238**

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		2,177	7,303
Depreciation and amortisation		9,651	8,819
Impairments – net reversal		5,337	507
(Increase)/decrease in inventories		(336)	(224)
(Increase)/decrease in receivables		9,273	22,746
Increase/(decrease) in trade and other payables		8,239	(4,574)
Increase/(decrease) in other current liabilities		1,164	(18)
Increase/(decrease) in provisions	25	1,099	(255)
Other movements in operating cash flows		(1,738)	(309)
Net cash inflow/(outflow) from operating activities		**34,866**	**33,995**
Cash flows from investing activities			
Interest received		11	369
Purchase of property, plant and equipment and intangible assets		(33,356)	(20,582)
Proceeds from sales of property, plant and equipment		12,626	-
Net cash inflow/(outflow) from investing activities		**(20,719)**	**(20,213)**
Net cash inflow/(outflow) before financing		**14,147**	**13,782**
Cash flows from financing activities			
Public Dividend Capital received		16,939	4,156
Capital element of finance lease rental payments		(1,993)	(1,705)
Interest element of finance lease		(265)	(339)
Dividends paid		(5,718)	(6,295)
Net cash inflow/(outflow) from financing activities		**8,963**	**(4,183)**
Net increase/(decrease) in cash and cash equivalents		**23,110**	**9,599**
Cash (and) cash equivalents at the beginning of the year		**53,470**	**43,871**
Cash (and) cash equivalents at 31 March	**21**	**76,580**	**53,470**

Notes to the Accounts 31 March 2021

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 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.

1.2 Accounting convention

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

1.3 Going concern

These accounts have been prepared on a going concern basis. 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.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

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

Key sources of estimation uncertainty

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

Incomplete inpatient episodes as at 31 March: where a patient occupies a bed at the financial year end an estimated value for the partially completed spell is calculated using a bed day rate multiplied by the number of days that bed has been occupied. In 2020/21 the NHS had block contract arrangements in place and as such there were no incomplete patient episodes with commissioners at 31 March 2021 £nil (2019/20 £2,438,000).

Untaken annual leave: Employee Benefits includes an estimate for the value of annual leave earned but not taken at the end of each financial year, and is calculated using an average of the number of days per employee per staff group. The Trust has based the average number of days per staff group on records of annual leave remaining for a sample of 46.4% of staff. The number of days has been increased from 1.00 in 2019/20 to 5.81 in 2020/21; this reflects the fact that a number of staff cancelled planned leave to help the Trust during the COVID pandemic. In 2020/21 this equated to £4,637,000 (2019/20: £668,000) and the year on year increase is accounted for as a salary cost/benefit and reported within note 7, with matching income from NHS England within note 3.1.

Provisions: values for provisions are based upon data received from NHS Pensions Agency, NHS Resolution, expert opinion from within the Trust and external professional advisors regarding when settlement will be made. More information is set out in note 25.

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

1.5 Revenue

1.5.1 Revenue

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

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

The Trust's income predominantly derives from the delivery of healthcare activity.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services

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 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

For 2020/21 and 2019/20

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

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

Revenue from research contracts

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

NHS injury cost recovery scheme

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

1.5.2 Revenue grants and other contributions to expenditure

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

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

1.5.3 Other income

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

1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

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

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

Land and buildings used for the Trust's services, or for administrative purposes, are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

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

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

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

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

Subsequent expenditure

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

1.9 Intangible assets

Recognition

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

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

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

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

Measurement

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

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

1.10 Depreciation, amortisation and impairments

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

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

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

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

1.11 Donated and grant funded assets

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

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

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.

1.12 Non-current assets held for sale

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

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

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

1.13 Leases

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

The Trust as lessee

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

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

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

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

1.14 Inventories

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

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.

1.15 Cash and cash equivalents

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

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

1.16 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.17 Provisions

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

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury for the financial year, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of negative 0.95% (2019/20- negative 0.50% in real terms). These rates are as follows:

- Short-term (up to 5 years): Negative 0.02%
- Medium-term (after 5 years up to 10 years): 0.18%
- 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:

- Year 1: 1.20%
- Year 2: 1.60%
- Into perpetuity: 2.00%

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

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

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

1.18 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25.

1.19 Non-clinical risk pooling

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

1.20 Contingencies

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

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

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

1.21 Financial assets and financial liabilities

1.21.1 Recognition

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

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

1.21.2 Classification and measurement

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

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

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

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

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

Impairment of financial assets

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

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

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

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

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

1.21.3 Derecognition

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

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

1.22 Value Added Tax

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

1.23 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- Monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

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

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

1.24 Corporation Tax

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

1.25 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 30 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust and represents the Department of Health's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued 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 (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.27 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.28 Subsidiaries

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

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

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

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

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

The Trust is the Corporate Trustee of the linked NHS Charity, The Ashford and St. Peter's Hospitals Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK FRS 102. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are disclosed as related party transactions in note 29.

1.29 Joint ventures

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

1.30 Joint operations

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

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

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

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

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 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 a rate 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. 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 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 DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted

2. Operating Segments

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

	2020/21			2019/20		
	Clinical Divisions £'000	Other £'000	Total £'000	Clinical Divisions £'000	Other £'000	Total £'000
Income	15,572	371,700	387,272	15,310	328,132	343,442
Expenditure	(275,139)	(115,791)	(390,930)	(265,579)	(76,676)	(342,255)
Contribution	**(259,567)**	**255,909**	**(3,658)**	**(250,269)**	**251,456**	**1,187**

The prior year income split has been amended to be comparable to the split of income in 2020/21 under block contract income arrangements.

3. Income from patient care activities

3.1 Income from activities

	2020/21	2019/20
		Restated
	£'000	£'000
Analysis by activity		
Block contract / system envelope income	305,650	283,370
High cost drugs income	15,304	16,781
Additional pension contribution central funding	8,870	7,979
Private Patient income	1,577	1,905
Other non-protected clinical income	5,151	2,207
Total	**336,552**	**312,242**

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.

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

Other non-protected clinical income includes £3,969,000 of funding towards the increased cost of the Trust's annual leave accrual (see note 1.4).

		2020/21 £'000	2019/20 £'000
Activity by source			
Clinical Commissioning Groups and NHS England		333,878	308,925
Department of Health and Social Care		20	20
Local Authorities		173	133
Non-NHS	- Private patients	1,577	1,905
	- Overseas patients (non-reciprocal)	251	556
	- Injury cost recovery	597	581
	- Other	56	122
Total		**336,552**	**312,242**

Injury cost recovery income is subject to a provision for impairment of receivables of 22.43% (2019/20 – 21.79%) to reflect expected rates of collection.

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. Income from Commissioner Requested Services in 2020/21 was £309,377,000 (2019/20- £295,695,000).

3.2 Income from overseas patients

	2020/21 £'000	2019/20 £'000
Income recognised this year	251	556
Cash payments received in year	180	224
Amounts added to the provision for impairment of receivables	229	-
Amounts written off in year	125	151

4. Other operating income

	2020/21 £'000	2019/20 £'000
Other operating income from contracts with customers		
Research and development	1,647	1,233
Education and training	11,428	9,963
Non-patient care services to other bodies	1,014	1,485
Provider sustainability fund income	-	5,098
Marginal rate emergency tariff funding	-	2,781
Reimbursement and top up funding	18,292	-
Other income:		
Car parking	608	2,323
Catering	413	-
Estates recharges	310	348
Pharmacy sales	1,347	1,295
Nursery	877	1,044
Other	5,959	5,028
Other non-contract operating income		
Education and training – notional income from apprenticeship fund	504	293
Charitable and other contributions to expenditure	424	309
Donated equipment from DHSC for COVID response	1,314	-
Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold	153	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	6,430	-
Total	**50,720**	**31,200**

As a result of the financial framework in place during 2020/21, particularly during the first half of the financial year, the Trust received £18,292,000 of reimbursement and top-up funding. In the second half of 2020/21 such funding is shown within block contract/system envelope income (note 3.1).

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed. In 2019/20 this included car parking and nursery charges, however due to COVID the income from both of these services fell below £1m during 2020/21.

	2020/21 £'000	2019/20 £'000
Income	-	3,365
Full Cost	-	(3,336)
Surplus/(deficit)		**29**

5. Operating expenses

	2020/21 £'000	2019/20 £'000
Purchase of healthcare from NHS and DHSC bodies	3,479	5,311
Purchase of healthcare from non-NHS and non-DHSC bodies	16,598	16,483
Employee benefits – Non-Executive Directors	161	146
Employee benefits – staff and Executive Directors	240,741	214,932
Gross redundancy payments	-	341
Drugs costs	20,870	20,980
Supplies and services – clinical (excluding drugs)	30,292	31,245
Supplies and services – clinical – consumables donated by DHSC group bodies for COVID response	6,187	-
Supplies and services – general	5,391	4,211
Establishment	2,890	3,889
Transport	905	827
Premises	17,831	12,241
Increase/(decrease) in provision for impairment of receivables	393	(744)
Depreciation and amortisation	9,651	8,819
Impairments of property, plant and equipment net of (reversals)	5,337	507
Auditors remuneration	90	77
Internal audit	55	55
NHS clinical negligence scheme	14,409	11,835
Legal fees	477	222
Consultancy costs	1,402	1,139
Training, courses and conferences	1,707	1,118
Rentals under operating leases	659	655
Insurance	345	301
Losses, ex gratia and special payments	162	136
Other	**5,063**	**1,413**
	385,095	**336,139**

This note includes irrecoverable VAT.

Auditors' remuneration

	2020/21 £'000	2019/20 £'000
Audit services – statutory audit	56	56
Audit services – audit related regulatory reporting	12	2
	68	**58**

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

As a result of the new Code of Audit Practice requirements there has been a change in which external auditors report their findings in relation to Value for Money. The amount shown above in 2020/21 includes an allowance for increased fees.

Audit Liability Cap

An engagement letter dated 11 January 2021 was signed with Mazars. Currently the liability of Mazars, its members, partners and staff (whether in contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit is unlimited.

6. Operating leases

As lessee:

	2020/21 £'000	2019/20 £'000
Payments recognised as an expense		
Minimum lease payments	659	655
Total	**659**	**655**

	31/03/21 £'000	31/03/20 £'000
Total future minimum lease payments		
Not later than one year	602	606
Between one and five years	869	1,393
Later than five years	-	-
Total	**1,471**	**1,999**

7. Employee benefits

	2020/21 £'000	2019/20 £'000
Salaries and wages	187,415	162,169
Social security costs	18,511	16,346
Employer's contribution to NHS pensions	20,411	18,349
Pension cost - employer contributions paid by NHS England on the Trust's behalf (6.3%)	8,870	7,979
Apprenticeship levy	891	797
Pension cost – other	32	26
Temporary staff (including agency)	13,266	16,263
Total gross staff costs	**249,396**	**221,929**
Recoveries in respect of seconded staff	(8,655)	(6,997)
Total staff costs	**240,741**	**214,932**
Of which		
Costs capitalised as part of assets	**697**	**913**

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

8. Pension costs

8.1 NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

8.2 National Employment Savings Scheme (NEST)

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

9. Retirements due to ill-health

During the year ended 31 March 2021 there were three early retirements (2019/20- three) from the Trust agreed on the grounds of ill-health with a value of £113,000 (2019/20 - £149,000).

10. Better Payment Practice Code

Better Payment Practice Code - measure of compliance

	2020/21		2019/20	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the year	82,947	142,779	93,755	131,027
Total Non-NHS trade invoices paid within target	73,323	129,333	87,447	118,209
Percentage of Non-NHS trade invoices paid within target	**88.40%**	**90.58%**	**93.27%**	**90.22%**
Total NHS trade invoices paid in the year	1,447	12,991	1,817	20,065
Total NHS trade invoices paid within target	993	9,216	1,214	15,513
Percentage of NHS trade invoices paid within target	**68.62%**	**70.93%**	**66.81%**	**77.32%**

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

11. Finance income

	2020/21 £'000	2019/20 £'000
Interest revenue		
Bank accounts	-	358

12. Finance expense

	2020/21 £'000	2019/20 £'000
Interest costs		
Interest on obligations under finance leases	265	339

13. Other gains and losses

	2020/21 £'000	2019/20 £'000
Losses on disposal of property, plant and equipment	(2)	-
	-	-
Total	**(2)**	**-**

14. Property, plant and equipment

2020/21	Land £'000	Buildings excluding dwellings £'000	Assets under construction and payments on account £'000	Plant and machinery £'000	Transport and equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Cost or valuation at 1 April 2020	**24,470**	**135,086**	**11,170**	**42,996**	**132**	**16,179**	**5,086**	**235,119**
Additions purchased	-	5,489	29,341	2,298	19	725	337	38,209
Additions leased	-	-	-	959	-	-	-	959
Additions donated	-	-	-	257	-	82	85	424
Additions donated from DHSC for COVID response (non-cash)	-	-	-	1,314	-	-	-	1,314
Reclassifications	-	22,527	(24,371)	1,355	-	123	199	(167)
Impairments charged to operating expenses	-	(5,337)	-	-	-	-	-	(5,337)
Impairments charged to the revaluation reserve	-	(10,337)	-	-	-	-	-	(10,337)
Reversal of impairments credited to revaluation reserve	2,620	-	-	-	-	-	-	2,620
Revaluations	10	(4,153)	-	-	-	-	-	(4,143)
Disposals/derecognition	-	-	-	(11)	(16)	(922)	(199)	(1,148)
At 31 March 2021	**27,100**	**143,275**	**16,140**	**49,168**	**135**	**16,187**	**5,508**	**257,513**
Depreciation at 1 April 2020	-	-	-	31,781	71	13,306	4,490	49,648
Charged during the year	-	4,153	-	2,966	11	1,082	216	8,428
Revaluations	-	(4,153)	-	-	-	-	-	(4,153)
Disposals/derecognition	-	-	-	(11)	(7)	(922)	(199)	(1,139)
Depreciation at 31 March 2021	-	-	-	34,736	75	13,466	4,507	52,784
Net book value at 31 March 2021	**27,100**	**143,275**	**16,140**	**14,432**	**60**	**2,721**	**1,001**	**204,729**
Net book value								
Purchased	27,100	140,571	16,140	7,172	60	2,643	897	194,583
Finance leased	-	1,796	-	5,393	-	-	-	7,189
Donated	-	908	-	638	-	78	104	1,728
Donated from DHSC for COVID response	-	-	-	1,229	-	-	-	1,229
Total at 31 March 2021	**27,100**	**143,275**	**16,140**	**14,432**	**60**	**2,721**	**1,001**	**204,729**

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

The Trust had desktop valuations of its land and buildings carried out as at 31 March 2020 and 31 March 2021 by Cushman and Wakefield. These resulted in impairments and revaluations for 2019/20 and 2020/21 as set out in the tables above. The effects on income and expenditure and revaluation reserve for those financial years are shown in note 16.

The economic lives of property, plant and equipment are:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	8	80
Plant and Machinery	3	15
Transport Equipment	5	10
Information Technology	3	10
Furniture and Fittings	5	10

15. Intangible fixed assets

2020/21	Software Licences £'000	Total £'000
Gross cost at 1 April 2020	12,569	12,569
Reclassifications	167	167
Additions purchased	754	754
Gross cost at 31 March 2021	**13,490**	**13,490**
Amortisation at 1 April 2020	7,107	7,107
Charged during the year	1,223	1,223
Amortisation at 31 March 2021	**8,330**	**8,330**
Net book value		
- Purchased	5,160	5,160
- Donated	-	-
Total at 31 March 2021	**5,160**	**5,160**

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

The Revaluation Reserve balance for intangible assets is £nil (2019/20 - £nil).

The economic lives of intangible assets are:

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

16. Impairments

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

	2020/21		2019/20	
	Income and Expenditure £'000	Revaluation Reserve £'000	Income and Expenditure £'000	Revaluation Reserve £'000
Revaluation of Estate				
- Revaluation of land and buildings	-	10	-	147
- Impairment of land and buildings	5,337	(10,337)	(531)	(12,548)
- Reversal of prior year impairments of buildings	-	2,620	24	270
Total net	**5,337**	**(7,707)**	**(507)**	**(12,131)**

17. Capital commitments

Contracted capital commitments were as follows:

	31/03/21 £'000	31/03/20 £'000
Property, plant and equipment	7,806	10,145
Intangibles	-	-
Total	**7,806**	**10,145**

As set out in Note 24, in 2013/14 the Trust entered into a Managed Equipment Service contract for Imaging equipment and £2,374,000 (2019/20- £3,196,000) is included in the above total in respect of this contract.

18. Other investments

	31/03/21 £'000	31/03/20 £'000
Carrying value at 1 April	60	60
Movement in fair value through income and expenditure	-	-
Carrying value at 31 March	**60**	**60**

The Trust holds 900 Class C shares in Beautiful Information Limited- these were purchased for £120,000 in October 2016. Following a fair value review of this investment the carrying value was reduced by £nil in 2020/21 (2019/20- £nil).

19. Inventories

	31/03/21 £'000	31/03/20 £'000
Drugs	1,039	1,063
Consumables	3,047	2,687
Energy	23	23
Total	**4,109**	**3,773**

In response to the COVID 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 £6,430k of items purchased by DHSC. These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in operating expenses.

20. Trade and other receivables

20.1 Trade and other receivables

	Current		Non-current	
	31/03/21 £'000	31/03/20 £'000	31/03/21 £'000	31/03/20 £'000
Contract receivables	8,774	17,273	640	656
Capital receivables	7,222	13,428	-	6,413
Allowance for impaired contract receivables/assets	(1,125)	(759)	-	-
Prepayments	2,321	1,653	-	-
VAT	1,022	1,723	-	-
PDC dividend receivable	412	262	-	-
Other receivables	453	868	-	-
Clinician pension tax provision reimbursement funding from NHS England	-	-	296	251
Total	**19,079**	**34,448**	**936**	**7,320**

Capital receivables include £7,217,000 (2019/20: £19,775,000) due from Cala Homes following the sale of the West Site, St. Peter's Hospital in 2018/19. Of this £7,217,000 (2019/20: £13,362,000) is within current capital receivables and £nil (2019/20: £6,413,000) is shown as non-current capital receivables.

20.2 Allowances for credit losses

	31/03/21		31/03/20	
	Contract receivables and contract assets £'000	All other receivables £'000	Contract receivables and contract assets £'000	All other receivables £'000
Allowances at 1 April - brought forward	**759**	**-**	**1,580**	**-**
New allowances arising	477	-	246	-
Changes in existing allowances	106	-	(95)	-
Reversals of allowances	(190)	-	(895)	-
Utilisation of allowances (write offs)	(27)	-	(77)	-
Allowances at 31 March	**1,125**	**-**	**759**	**-**

21. Cash and cash equivalents

	31/03/21 £'000	31/03/20 £'000
Cash with Government Banking Service	76,562	53,451
Commercial banks and cash in hand	18	19
Balance at 31 March	**76,580**	**53,470**

22. Trade and other payables

	Current		Non-current	
	31/03/21 £'000	31/03/20 £'000	31/03/21 £'000	31/03/20 £'000
Trade payables	8,245	9,277	-	-
Capital payables	13,921	8,314	-	-
Accruals	18,398	10,160	-	-
Other payables	9,180	8,147	-	-
Trade and other payables	**49,744**	**35,898**	**-**	**-**
Deferred income: contract liabilities	1,457	293	-	-
Other liabilities	**1,457**	**293**	**-**	**-**

23. Borrowings

	Current		Non-current	
	31/03/21 £'000	31/03/20 £'000	31/03/21 £'000	31/03/20 £'000
Finance lease liabilities	**1,921**	**1,828**	**3,758**	**4,885**

24. Finance lease obligations

Amounts payable under finance leases:	Minimum lease payments	
	31/03/21 £'000	31/03/20 £'000
Within one year	2,179	2,116
Between one and five years	3,452	4,559
Later than five years	654	875
Less future finance charges	(606)	(837)
Net lease liabilities	**5,679**	**6,713**

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

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

25. Provisions for liabilities and charges

	Pensions – early departure costs £'000	Pensions - injury benefits £'000	Legal claims £'000	Clinician pension tax reimbursement £'000	Other £'000	Total £'000
At 1 April 2020	**107**	**39**	**43**	**251**	**1,422**	**1,862**
Arising during the year	343	214	8	45	938	1,548
Used during the year	(41)	(23)	(16)	-	(277)	(357)
Reversed unused	-	-	(11)	-	(81)	(92)
At 31 March 2021	**409**	**230**	**24**	**296**	**2,002**	**2,961**

Expected timing of cashflows:

Not later than one year	41	23	24	-	2,002	2,090
Later than one year and not later than five years	164	92	-	296	-	552
Later than five years	204	115	-	-	-	319
As at 31 March 2021						
Current	41	23	24	-	2,002	2,090
Non-Current	368	207	-	296	-	871
As at 31 March 2020						
Current	38	23	43	-	1,422	1,526
Non-Current	69	16	-	251	-	336

Clinical negligence provisions

Included in the provisions of NHS Resolution at 31 March 2021 is £178,125,000 (2019/20- £191,875,000) in respect of clinical negligence liabilities of the Trust.

Legal claim provisions

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

In addition to these provisions, contingent liabilities in respect of the claims are given in note 26.

Clinician pension tax reimbursement

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

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

In 2019/20 the Trust created a provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This will be offset by the commitment from NHS England and the Government to fund the payments to clinicians as and when they arise. The provision and offsetting asset will initially increase year on year in line with the pension scheme growth, and be released as commitments are met, i.e. as eligible members retire under the rules of the NHS Pension Scheme.

In 2020/21 the movement in provision reflects a change in the average discounted value per nomination.

Other provisions

Other provisions at 31 March 2021 include: -

- £20,000 (2019/20: £150,000) in respect of clinical excellence awards;
- £157,000 (2019/20: £104,000) in respect of employment tribunal claims;
- £85,000 (2019/20: £128,000) in respect of consultants pay appeals;
- £1,051,000 (2019/20: £1,040,000) in respect of cost provisions associated with land sales completed in March 2019 – predominantly S106 requirements from the local council; and
- £689,000 (2019/20: £nil) in respect of a VAT provision relating to a service contract.

26. Contingent assets/(liabilities)

Other

Other Contingent Liabilities for non-clinical negligence incidents total £8,000 (2019/20-£22,000).

27. Financial instruments

27.1 Carrying value of financial assets

	31/03/21			31/03/20		
	Held at amortised cost £'000	Held at fair value through I&E £'000	Total book value £'000	Held at amortised cost £'000	Held at fair value through I&E £'000	Total book value £'000
Trade and other receivables	16,259	-	16,259	38,129	-	38,129
Other investments	-	60	60	-	60	60
Cash and cash equivalents at bank and in hand	76,580	-	76,580	53,470	-	53,470
Total at 31 March	**92,839**	**60**	**92,899**	**91,599**	**60**	**91,659**

27.2 Carrying value of financial liabilities

Carrying values of financial liabilities as at 31 March 2020:

	31/03/21		31/03/20	
	Held at amortised cost £'000	Total book value £'000	Held at amortised cost £'000	Total book value £'000
Trade and other payables excluding non-financial liabilities	44,244	44,244	30,865	30,865
Obligations under finance leases	5,679	5,679	6,713	6,713
Total at 31 March	**49,923**	**49,923**	**37,578**	**37,578**

27.3 Fair values of financial assets and liabilities

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

27.4 Maturity of financial liabilities

	31/03/21	31/03/20 Restated
	£'000	£'000
In one year or less	46,423	32,981
In more than one year but not more than five years	3,452	4,559
In more than five years	654	875
Total at 31 March	**50,529**	**38,415**

This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

27.5 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

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

Interest Rate Risk

The Trust can borrow from Government for capital expenditure, subject to affordability. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Interest charged on finance leased assets are at fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

Because of the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the Trade and other receivables note. The Trust recognises that the public sector funding environment, with the continued pressure of demand and its consequences for allocations for Clinical Commissioning Groups, leads to an increase in credit risk for the Trust.

Liquidity risk

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

28. Events after the reporting period

There were no events after the reporting period requiring disclosure.

29. Related party transactions

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Ashford and St. Peter's Hospitals NHS Foundation Trust. However, Non-Executive Director Marcine Waterman has declared her role as Central Government Faculty Board Member at CIPFA to which the Trust paid £nil in 2020/21 (2019/20: £246). Ex Non-Executive Director Hilary McCallion, who left in 2019, had declared her role as a Trustee for Dementia UK to which the Trust paid £2,000 in 2019/20.

As set out in note 18 the Trust purchased shares in Beautiful Information Limited in October 2016. As a result of this investment the Trust is able to appoint one Director to the Board of Beautiful Information Limited which is currently the Trust's Director of Finance and Information. There is no remuneration or other form of personal benefit for this role. During 2020/21 the Trust procured £167,000 of services from Beautiful Information Limited (2019/20: £60,000).

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

- NHS England
- Health Education England
- NHS Surrey Heartlands CCG
- NHS Hounslow CCG
- NHS East Berkshire CCG
- NHS South West London CCG
- NHS Surrey Heath CCG
- NHS Kent and Medway CCG
- NHS North East Hampshire and Farnham CCG
- Frimley Health NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust
- Royal Surrey NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- NHS Blood and Transplant
- NHS Resolution
- NHS Pensions Scheme
- NHS Property Services
- NHS Business Services Authority
- NHS Supply Chain

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

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

30. Third party assets

The Trust held £9,000 cash at bank and in hand at 31 March 2021 (2019/20- £9,000) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31. Losses and special payments

Losses and special payments are transactions that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. Payments are made in accordance with the HM Treasury publication "Managing Public Money".

There were 89 cases (2019/20 – 83) of losses and special payments totalling £182,000 paid in 2020/21 (2019/20- £227,000). There were no cases where the net payment exceeded £100,000. Total costs included in this note are on an accruals basis excluding provisions for future losses.

	31/03/21		31/03/20	
	No. of Cases	Total	No. of Cases	Total
	£'000	£'000	£'000	£'000
Losses of cash	31	23	2	3
Bad debts and claims abandoned	26	128	26	152
Ex gratia payments	32	31	55	72
Total at 31 March 2020	**89**	**182**	**83**	**227**

32. Event after the reporting date

The UK Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2021/22, and CCG allocations have been set for the remainder of 2021/22. While these allocations may be subject to minor revision as a result of the financial framework in the second half of the 2020/21 financial year, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year.

Providers can therefore expect NHS funding to flow at similar levels to that previously provided, where services are reasonably still expected to be commissioned. Whilst mechanisms for contracting and payment are not definitively in place in place for the second half of the year, it is clear that government financial support is available. For the period April 2021 to September 2021, the Trust is receiving income via an interim, nationally set, block contract and top-up arrangement.